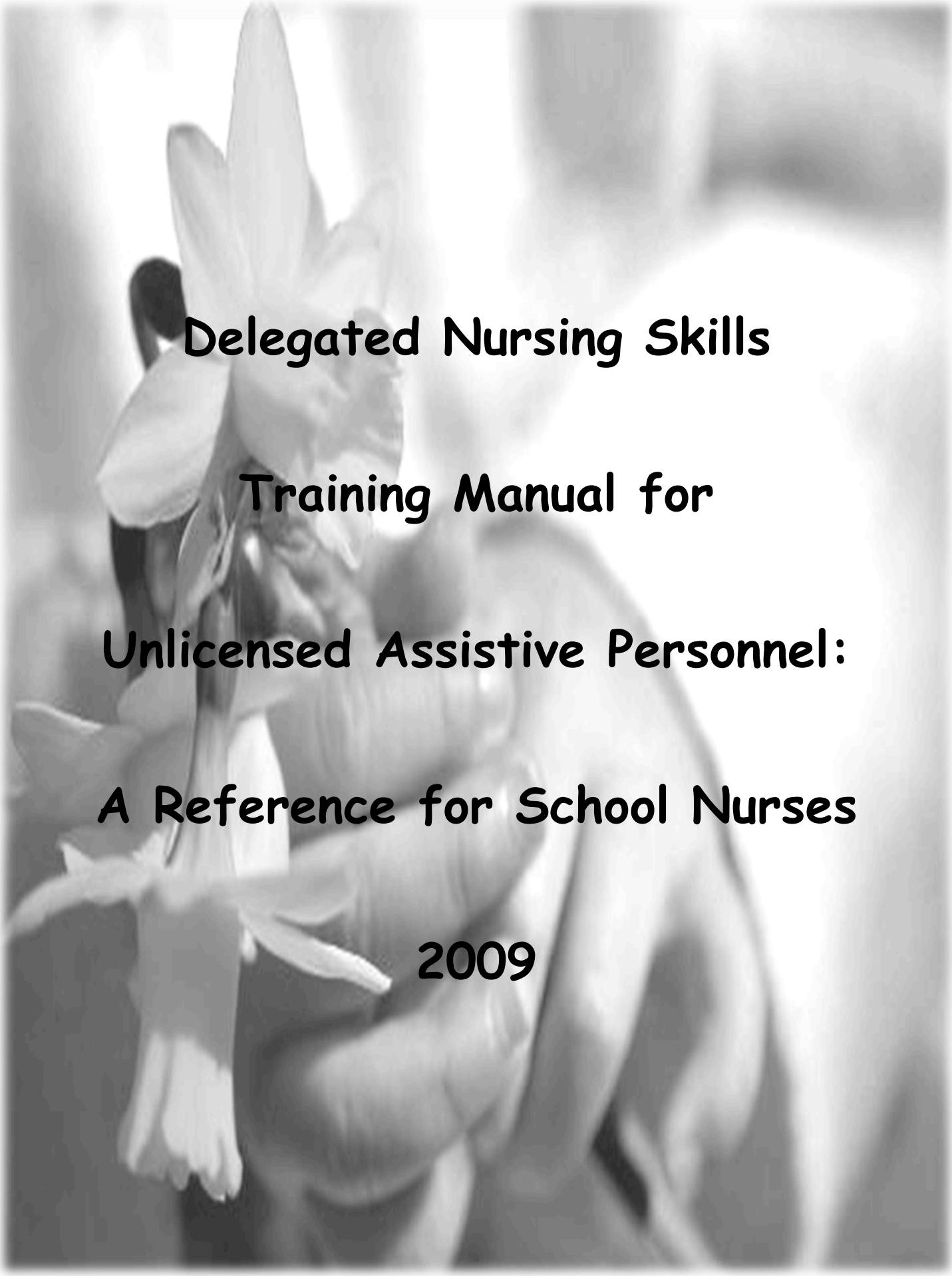

Delegated Nursing Skills

Training Manual for

Unlicensed Assistive Personnel:

A Reference for School Nurses

2009

I would like to say a special Thank You to all those nurses who took time out of their busy days to respond to the surveys! Your input was extremely helpful in this journey. I hope you all find this resource helpful enough to eliminate some of the stress I know school nurses face daily. I would

also like to thank my mentor Paula Smith for all of her time, expertise, and motivational power to keep me focused. I feel truly blessed to have been able to create this resource for all of our wonderful Arkansas School Nurses!

Sincerely,

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Introduction

As medical technology has made vast advancements which have improved the ability of our nation's children to remain in the schools, the need for specialized care has also advanced. Many school nurses are responsible for multiple buildings and hundreds sometimes even thousands of students. This responsibility has made the delegation of skilled nursing procedures inevitable. For the purpose of this manual the term "Unlicensed Assistive Personnel (UAP)" will be used. An Unlicensed Assistive Personnel is any individual chosen to assist in the care of one or more students who may require any skilled nursing procedure. Each school district reserves the right to define the position and job duties for these individuals; however, the Registered Nurse (RN) is responsible for training, supervision, and proper documentation of competency for these individuals.

This manual has been designed to assist the school nurse with training and documentation of skill competencies for UAPs. In addition, a section on delegation has been included to increase knowledge about the importance of proper delegation and decrease the discomfort some nurses may feel with the delegation process.

The manual is divided into sections as outlined in the Nursing Tasks matrix of the *School Nurse Roles & Responsibilities Practice Guidelines* approved by the Arkansas State board of Nursing, revised September 2007. Each section will give a brief overview of major concepts to include in UAP training followed by the appropriate skills checklist(s) associated with the section. The book is designed so the school nurse may print only the sections necessary for the student-specific teaching. The RN reserves the right to include or exclude information based on each student's individualized needs. This manual is merely a reference of important information designed specifically for the school nurse.

General Guidelines for Training

The training of unlicensed assistive personnel falls under the roles and responsibilities of the school nurse. Here are some guidelines to follow when considering this training. It is important for a school nurse to know and understand the school district's policy regarding who is qualified as unlicensed assistive personnel. In addition, it is necessary for a school nurse to consider the diversity of each individual and his/ her cultural practices and beliefs.

Training for healthcare related procedures should be done in a systematic and controlled method. The nurse should give general training, student-specific training and training for student involvement in self-care. When possible, the student should be allowed to assume as much responsibility in his/ her own care as can be safely allowed. When training is approached in this manner, the results are:

1. Safe and effective care for the student
2. Competence and confidence on the part of the care providers at school; and
3. Family confidence in the provision of services

General Training

General training is designed for people who have contact with a student with a special heath care need but who are not responsible for providing the necessary health care. This training creates:

1. a positive attitude among teachers, administrators, and classmates toward including students with a range of diverse needs in the school community.
2. an opportunity for school staff to discuss concerns.
3. an opportunity for school staff, family, and administrators to discuss the social, emotional, and educational impact of attending school with a peer who has a disability or chronic illness.
4. an opportunity to provide an overview of the student's health care needs and emergency plan.

The key components of general training would include:

1. **The health care plan (HCP)-** The school nurse, together with the parent, should review the physician's orders and HCP to determine appropriate information to include in a general training. This may include a brief description of the health condition and appropriate health care needs the student may have. This does NOT mean the health care plan should be distributed to each teacher. This information should be treated as confidential medical information. Information is shared on a "need to know" basis.
2. **The emergency plan**- A brief explanation of the student's emergency plan should be presented during general training. It is important to include:
    a. a review of the emergency plan and standard precautions;
    b. assurances that a procedure is in place;
    c. known location of copies of the plan;

d. recognition of emergency situations and appropriate responses; and
e. a clear designation of persons who will provide emergency services and how to reach them

3. **Awareness training** - Topics covered as part of such programs include, but are not limited to, noticing and understanding similarities and differences in people; learning about types of disabilities and health care conditions; feeling included and experiencing barriers; and showing cooperation, curiosity, and respect. Students assisted by medical technology and their families may want to share specific information with school personnel, classmates, and community providers. Awareness training often includes questions and answers about a student's condition and equipment. Parameters surrounding what kind of questions the family may not want to discuss should be reviewed prior to the training. The student/family always has the right to refuse to answer a question and they should know that prior to the training.

Student-Specific Training

Student-specific training is always necessary, even if school personnel have provided similar care to other students. People who are directly responsible for providing health care services to the student need comprehensive training to meet the individual needs of a student.

The key components of a student-specific training would include:

1. An overview of the training:
    a. Description of the health issues and required procedures
    b. Standard precautions
    c. Psychosocial implications, including privacy, confidentiality, and dignity; maximum involvement of student in self-care, and attitudes and preferences of the student and family
    d. Pertinent information from the HCP
    e. Communication network within the school and among school, home, and health care providers
2. Discussion of health care / medical procedures
    f. Basic anatomy and body mechanics
    g. Name and purpose of procedure
    h. Time(s) to be performed and length of time involved
    i. Teaching methods, such as trainer demonstration of the procedure; trainee demonstration of the procedure with a mannequin; trainee observation of the parent or trainer performing the procedure for the student; and documentation using skills checklists.
    j. Site where student's care will take place
    k. Confidentiality and student privacy issues
    l. Hygienic practices, including standard precautions
    m. Equipment and supplies required
    n. Lifting and positioning of the student
    o. Level of student involvement in self-care
    p. Precautions

q. Signs and symptoms requiring attention
r. Documentation of the procedure
s. Scheduled supervision and follow up

3. The emergency plan- It is important to review the following steps and responsibilities in an emergency plan:
    t. Signs of possible problems
    u. Recognition of possible problems
    v. Individual responsibilities
    w. Location of the emergency plan
    x. List of people to contact in case of an emergency
    y. Mock emergency drill plan

Student training

The ability of students to provide their own health care can provide them greater freedom in school and in the community. It will promote the goal of independent living into their adult years. Students can improve their self-care skills by improving their tolerance, direction, and/or independent completion of health care.

The key components of student training include:

1. **Increase tolerance for care**- Students achieve independence and tolerance of self care at varying levels depending on cognitive, physical, emotional, social, and cultural factors. Appropriate goals should be developed to increase their tolerance of care.
2. **Direct the care provider**- Many students with physical disabilities learn to direct the care provider and assist during aspects of the procedure.
3. **Achieve independence**- Other students will be able to learn to perform procedures independently. The degree of supervision needed may vary depending on the complexity of the care and the developmental level of the student. Depending on the preference of the student and family, procedures can be performed to facilitate inclusion with a peer.

There must be steps in place to assist in implementation, monitoring, and evaluation of these services. These steps would include:

1. Providing direct care as appropriate or supervising the student's health care provider(s).
2. Updating assessment of the student's health status periodically and at least annually.
3. Updating and evaluating the student's HCP.
4. Documenting, reviewing, and updating skills training.

*This section adopted with permission from the *Resource Guide for Developing School Policies and Training Programs for Children with Special Health Care Needs 2007.*

Laws and Practice Guidelines Overview

Many nurses become confused with all the wording and long statute code numbers when trying to locate needed information. Below are a few laws that are used frequently in school nursing. They are listed alphabetically by "purpose" for easy referencing.

Delegation: Ark. Code Ann. § 17-87-102 .A licensed Registered Nurse has the authority to delegate skills and tasks which fall within the guidelines of the job descriptions defined by the Arkansas Nurse Practice Act. These definitions can be found in Section III, Delegation, of this manual.

Family Educational Rights and Privacy Act (FERPA): 20 *U.S.C.* § 1232g; 34 *CFR* Part 99. This federal law protects the student's education record and applies to any institution which receives federal money. To obtain full guidelines please visit http://www.ed.gov/policy/gen/guid/fpco/ferpa/index.html .

(Health Insurance Portability and Accountability Act (HIPAA): 45 *CFR* Parts 160, 162, and 164 Established in 1996, this law governs the private health information of every consumer seeking medical assistance. This act allows "flow of health information needed to provide and promote high quality health care" while ensuring this information is strictly protected. HIPAA "is designed to be flexible and comprehensive to cover the variety of uses and disclosures that need to be addressed". To obtain full guidelines please visit http://www.hhs.gov/ocr/hipaa

Individualized Healthcare Plans: Ark. Code Ann. § 16-18-1005 (a)(6)(A) "students with special health care needs, including the chronically ill, medically fragile, technology-dependent and students with other health impairments shall have individualized health care plans."

Scopes of Practice: Each nationally certified or licensed [registered] individual is required to practice within certain guidelines. These guidelines are determined by a specific licensing board and will differ from state to state. These positions are, but not limited to, Advanced Practice Nurse (APN), Registered Nurse (RN), Licensed Practical Nurse (LPN), and Licensed Psychiatric Technician Nurse (LPTN). The descriptions of each are addressed in Section III Delegation of this manual.

Section IV

Delegation

Delegation

Delegation is sometimes a task with which many nurses are uncomfortable. Some believe the process puts his/her license on the line. Each state has separate rules and regulations by which nurses must practice. By understanding the laws and guidelines which govern practice, these fears can be decreased. Hopefully, through the information contained within this manual nurses will gain the understanding and knowledge necessary to comfortably delegate tasks. Nurses must understand that delegation and supervision are separate but equally important professional nursing roles. Delegation is more than the act of merely handing responsibility over to another individual.

In an attempt to decrease the vast differences in terminology and the language of *Delegation*, the American Nurses Association (ANA) and the National Council of State Boards of Nursing (NCSBN) combined forces to create a joint statement on delegation.

> ANA and NCSBN both define delegation as the process for a nurse to direct another person to perform nursing tasks and activities. NCSBN describes this as the nurse transferring authority while ANA calls this a transfer of responsibility. Both mean that a registered nurse (RN) can direct another individual to do something that that person would not normally be allowed to do. [Position statements from both associations] stress that the nurse retains accountability for the delegation.

While nurses may delegate skills, they must never assume they are free from the responsibility for the delegated task. Supervision of the individual remains the responsibility of the delegating nurse. The American Nurses Association defines supervision as "the active process of directing, guiding, and influencing the outcome of an individual's performance of an activity." Supervision does not require the supervisor to be physically present at all times, however, the supervisor must be available to critically watch and direct the individual to whom the task has been delegated. The amount of supervision required is directly related to the individual's experience, skills, and ability to perform tasks appropriately for the student(s) being served.

School nurses, though supervised administratively by a superintendent or principal, are responsible for health services and nursing care administered through the health services program. Schools may use a team consisting of RNs, LPNs, LPTNs, and/or Unlicensed Assistive Personnel (UAP) to provide health services. In accordance with the Nurse Practice Act §18-87-102 and Arkansas State board of Nursing Scope of Practice Position statement

RN: assess, diagnose, plan, implement and evaluate nursing care while

LPN / LPTN: observe, implement and evaluate nursing care under the direction of an

RN, APN, physician, or dentist

UAP: perform delegated nursing care in accordance with the ASBN rules.

Only the school nurse can determine medically necessary nursing care that can be safely delegated to unlicensed assistive personnel. Sometimes confusion exists when an unlicensed assistive person is asked to do a procedure that a parent has been dong at home. For example, some parents have been taught to give an intravenous medication. The assumption is made that because a parent has been administering the medication intravenously, any school employee can do it. Family members can legally provide nursing care

without a nursing license as an allowable exception to the Nurse Practice Act. However, when these services are transferred to the public, the Nurse Practice Act applies. While administrators, teachers, and parents may be helpful resources and allies, they may not have the knowledge base to make adequate judgments about delegation of medical or nursing care; nor can they be held legally accountable to the same extent a nurse will be liable for nursing care delivered. The school nurse may be accountable to the administrator for personnel issues but ***the nurse is responsible for directing nursing care.***

Safe and effective delegation follows five simple principles.

1. Right Task
    a. Is the task within the scope of practice?
    b. Is the task appropriate to the job description?
    c. Is the task on a shared tasks list?
    d. What is the desired outcome?
2. Right Circumstances
    a. Is the setting appropriate?
    b. Are there enough resources available?
    c. Are there any other factors to consider?
3. Right Person
    a. Is this person currently qualified or can they be qualified to do the task?
    b. Does this fit within his/ her job description?
    c. Basically –are you assigning the right person to the right task?
4. Right direction/communication
    a. Clear concise description of the task including objective, limits and expectations?
5. Right Supervisor
    a. Monitoring?
    b. Evaluation?
    c. Intervention?
    d. Feedback?

When nurses follow these principles and answer the questions appropriately, delegation will be successful.

Reference:

Hansten, R.I., & Jackson, M. (2004). *Clinical delegation skills* (3rd ed.). Sudbury, MA: Jones and Bartlett.

Section V

Activities of Daily Living

Activities of daily living can be defined as tasks performed by individuals everyday which allow the individual to function independently. Activities included in the basic activities of daily living include feeding, dressing, hygiene, and physical mobility.

The ability to perform activities of daily living may be hampered by illness or accident resulting in physical or mental disability. Health care workers play a significant role in teaching individuals to maintain or relearn these skills so the individual may achieve the highest level of functioning.

Elimination

Some students may need assistance with toileting, bowel and bladder training, and some students will require the use of diapers. Students with elimination difficulties may require psychosocial and physiological assistance. It is important to remember compassionate care and respect for the student is of utmost importance during assistance with elimination.

Toileting

In order to decrease the anxiety a student may feel with the exposure while toileting, remember to treat the student with respect and provide as much privacy as possible.

Key Points for Toileting

1. Assist the student to the restroom.
2. Assist the student with removal of clothing.
3. Apply gloves.
4. Assist the student to the toilet—*Remember proper body mechanics will reduce the risk of back injury*
5. Provide privacy while remaining close to the student in case he/she needs assistance. Providing balance or support for the student may be needed.
6. Once the student is finished with elimination, remind the student to use correct methods to clean perineal area. Girls should use a front-to-back motion for cleansing. The student may require assistance with this procedure.
7. Assist the student with replacing his/her clothing.
8. Wash hands—Caregiver and the student.
9. Assist the student back to the classroom.
10. DOCUMENT PROCEDURE.
11. Notify RN of any changes in elimination or any concerns.

Documentation is a critical component to any procedure. Occurrences to watch for and document with toileting are

1. Foul smelling urine or difficulty expelling urine.
2. Complains of pain or discomfort with elimination.
3. Change in color of the urine.

If any of these occur, notify the RN immediately.

Diapering

In order to decrease the anxiety some students may experience with this procedure, it is important to reduce the amount of time the student is exposed. To decrease the time a student may be exposed, gather all needed supplies and setting up the area first.

Points to Remember

1. Gather supplies and set area up first.
2. Wash hands.
3. Bring student to changing area and provide privacy.
4. Place student on changing table—*remember proper body mechanics will reduce the risk of back injury. If a second person is needed to assist with lifting, have them present before beginning the procedure.*
5. Apply gloves.
6. Remove only enough clothing enough to gain access to the diaper.
7. Remove soiled diaper.
8. Clean perineal area—remember to use the front-to-back motion with girls. This will decrease risk of infection.
9. If there is an order to use skin barriers such as Desitin™ or Vaseline™, apply barrier at this time.
10. Apply a clean diaper and replace clothing.
11. Dress student.
12. Dispose of soiled diaper properly.
13. Wash hands.
14. Return student to the classroom.
15. DOCUMENT PROCEDURE.

Documentation is a critical component to any procedure. Things to watch for and document with toileting are

1. Foul smelling urine or stool or difficulty expelling urine or stool.
2. Complains of pain or discomfort with elimination.
3. Change in color of the urine or color/consistency of stool.
4. Note any changes in skin such as extreme redness, bleeding or breakage of skin.

If any of these occur, notify the RN immediately.

Toileting/Diapering (ASBN 1.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
Diapering			
1. Gather needed supplies (diapers, wipes, skin barrier if prescribed) and wash hands			
2. Bring student to designated area for changing and provide privacy			
3. Assist student to changing table remembering to use proper body mechanics and have 2nd person to assist if needed			
4. Apply gloves and remove clothing to expose diaper			
5. Remove soiled diaper			
6. Cleanse skin with appropriate materials for student			
7. Note any changes in skin—Report abnormal findings (such as extreme redness, bleeding or breakage of skin) to School Nurse			
8. **Apply skin cream as prescribed if order is present**			
9. Apply clean diaper			
10. Replace clothing			
11. Assist student back to classroom remembering to use proper body mechanics			
12. Document procedure			
Toileting			
1. Assist student to restroom. Remembering to use proper body mechanics			
2. Apply gloves and assist student to toilet			
3. Assist with removal of clothing to allow use of toilet			
4. Provide privacy while remaining next to student for support			
5. Assist student with cleaning perineal area			
6. Assist student with replacement of clothing			
7. Assist student back to classroom remembering to use proper body mechanics			
8. Document procedure			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Elimination Impairment

Some students may have elimination impairment due to structural abnormalities or certain disease processes. Some students may be able to regain partial or complete control of elimination through bowel or bladder training. Please refer to the student specific training guidelines if available. In the event a student does not have a formal written bowel or bladder program the nurse may use this section as a guideline.

Any training program is established to use and enhance the student's natural urges. Success of the program is strongly increased when consistency, good nutrition, and timing are observed. To this end, a pattern of normal elimination must be established. This can be developed by watching and documenting the student's normal elimination pattern over a set period of time, usually five days are sufficient. Once a pattern has been established a student specific plan may be developed. Students with disabilities may not adapt to toilet training like those students without disabilities; therefore, special considerations must be taken. These students may have reduced sensation for the need to empty the bowel or bladder. The goal is to form a habit for toileting.

Some key points to remember are:

1. Preparation for toilet training is essential for a successful program. In addition to watching for normal elimination patters, keep a record of intake and output.
2. Consistency is critical. Do not start the program until a consistent pattern can be established (i.e. do not begin the program at school in the middle of the week or right before the weekend. Try to begin on a Monday).
3. Consistency between school training and home training is important. Make sure the parent(s)/ guardian(s) is ready to begin the process as well.
4. Have the child wear clothes that are easy to pull up and down. This will help eliminate accidents related to difficulty in removing clothing.
5. Coordinate with parent/guardian to determine the appropriate word which will be used at home such as "potty".
6. Make a picture schedule using photos of all the steps necessary in the toileting procedure. Review the procedure with the student and place the photos in the correct order, then locate the pictures in a place clearly visible to the student.
7. Eliminate objects in the bathroom that could be a distraction for the student.
8. Establish a pattern of elimination (based upon the information gathered from the earlier studied elimination patterns of the student).
   ****NOTE: do not place the child randomly on the toilet randomly throughout the day. This may cause a disconnection between the toilet and elimination if no results occur.
9. Each school day, attempt elimination within 15 minutes of the designated time.
10. If possible, give the student fluids approximately 20-30 minutes before the scheduled toileting time.
11. Normal elimination of stool happens within 30 minutes of a meal.

12. If dry clothes are noted at elimination time give the student praise. If the student is wet at the first attempt only give praise for elimination in the toilet. Allow the student to sit on the toilet for approximately 3 minutes.
13. If the student eliminated in the toilet provide positive reinforcement. Remember to provide praise only AFTER the child has finished eliminating. This will prevent frightening the child and causing elimination to stop. Allowing the student to blow bubbles is a good example for providing praise. If the student does not eliminate DO NOT scold the child. Provide encouragement for the next elimination session.
14. If a picture schedule was created, review it with the student throughout the process and ask questions such as “What do we do next?”
15. If necessary, assist the student with hygiene and redressing.
16. Assist the student with proper hand washing and returning to the classroom.
17. DOCUMENT PROCEDURE

Bowel / Bladder Training (ASBN 1.2) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date
1. Elimination record will begin on _____and end on _____			
2. Ensure the student wears non restrictive clothing			
3. The term _____will be used for bowel / bladder training			
4. Create a picture schedule			
5. Eliminate all distracting items from the bathroom			
6. Elimination attempts will occur at the following times (remember normal elimination of stool occurs within 30 minutes of a meal) _____am/pm _____am/pm _____am/pm _____am/pm			
7. Give fluids approximately 20-30 minutes prior to above mentioned times			
8. Apply gloves			
9. Assist student to the restroom and assist to the toilet. Provide additional support if needed			
10. Assist with hygiene and redressing if necessary			
11. Assist with hand washing and returning to the classroom			
12. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Dental and Oral hygiene

Children are usually school age when they begin the process of losing their deciduous or 'baby' teeth. These teeth are used as a guide for permanent teeth to enter the mouth. Proper care of teeth and gums is extremely important as teeth are crucial for chewing food to maintain proper nutrition. Some students are not able to properly care for their own teeth. As primary care givers in the school setting, it may be necessary to provide dental and oral care for these students (Kozier, Erb, Berman, & Burke, 2000).

Points to remember

1. Gather supplies—toothbrush, toothpaste, cup, water for rinsing and gloves.
2. Prepare the student.
3. Explain to the student what is to occur and try to make the procedure pleasant.
4. Moisten toothbrush and apply toothpaste.
5. Brush teeth being careful not to apply too much pressure. The gums are very sensitive and can easily bleed.
6. Allow the student to spit and rinse his/her mouth.
7. Be careful to only give enough water to rinse the mouth.

   Note: if a student is not allowed to have liquids by mouth, do not provide water. It would be best only to use oral sponges.

8. DOCUMENT CARE

Documentation is a critical component to any procedure. Things to look for when providing oral care:

1. Broken or loose teeth.
2. Mouth sores.

Dental Hygiene (ASBN 1.3) & Oral Hygiene (ASB 1.4) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Gather supplies			
2. Prepare the student			
3. Explain procedure to the student			
4. Apply gloves			
5. Moisten toothbrush and apply toothpaste			
6. Brush the teeth			
7. Allow student to spit			
8. Provide water to rinse if student is allowed liquids			
9. Document care.			
Special Considerations for Oral care: 1. Only use oral sponges for students who are at risk for aspiration 2. Those students who have difficulty swallowing do not allow to drink water			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Lifting/Positioning/ Transfers

Muscle movement and functioning may be altered as a result of a number of causes. Damage to a portion of a student's brain may result in a break in the transmission of impulses to the muscles and loss of the muscles' ability to function. In addition, muscles may lose their ability to contract because of disease or deterioration due to a decrease in the number of nerves acting upon them. They may also lose function due to lack of use. Chemical and/or electrical imbalances may also affect movement in a body.

Using proper body mechanics while lifting, transferring, and/or positioning students is extremely important. Preventing injury of the student and/or caregiver can be accomplished when utilizing proper body mechanics

Body mechanics can be defined as the coordinated effort of the musculoskeletal and nervous systems to maintain balance, posture, and body alignment during lifting, bending, moving and performance of activities of daily living (Medicaid in the schools, n.d). If any one of these parts of the body are altered or injured, the result can be loss or change in the body's ability to move.

Here are some guidelines to help ensure proper body mechanics:

1. Never lift a student who is too heavy. Seek assistance from another staff member.
2. Explain procedure to student and have him/her participate as much as possible.
3. Maintain lower back in good alignment at all times.
4. Tighten stomach muscles and tuck the pelvis; this provides balance and protects the back.
5. Provide a broad base of support by placing feet at least 12 inches apart.
6. Bend at the knees while keeping back straight; this helps to maintain a center of gravity and lets the strong muscles of the legs do the lifting.
7. When lifting, keep the weight of the student's body close to the caregiver's body, this action places the weight in the same plane as the lifter and close to the center of gravity for balance.
8. Maintain an erect trunk and bent knees. This will assure that multiple muscle groups work together in a synchronized manner.
9. To lift vertically, the best height is approximately 2 feet above the ground and close to the lifter's center of gravity.
10. When changing the direction of movement, pivot feet, turn with short steps, and turn the whole body without twisting the upper torso. When lowering a heavy object or student, always bend straight down toward the resting place, NEVER twist to lower the student or object. This will reduce the risk for twisting sprains and injuries to the back.
11. Use a verbal 1-2-3 count to coordinate movement with the student and other staff. This will prevent jerking movements that could lead to back strain and injury.

Lifting/Transfers/Positioning (ASBN 1.5) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Lifting and Transfers 1-person			
1. Explain procedure to student			
2. Place wheelchair at a 45° angle to desired end location (changing table, another chair, etc…)			
3. Lock wheels in place			
4. Raise chair if possible to height of table or have 2nd person to available for lifting if necessary			
5. Position self between student's knees bending slightly at the waist			
6. Position the student in the center of the chair			
7. Place arms under the student's armpits			
8. Bend at the knee then push upward to the standing position			
9. Turn entire body slowly toward desired ending location—do not twist at the waist only—this can cause injury			
10. Lower student and support if necessary			
11. Release brake and move chair out of way			
12. Document Procedure			
2-person Lifting and Transfer			
1. Place wheelchair parallel to table or chair and lock brakes			
2. Position one person to stand behind student—one person in front of student to one side of students knees			
3. One person places arms under the student's armpits while other person grasps student under both knees			
4. Each person bends knees at the same time and pushes straight up, lifting the student onto the table or chair and providing support when necessary			
5. Release brake and move chair out of way			
6. Document Procedure			
Positioning			
1. Keep student's airway open by ensuring head and neck are in straight alignment			
2. Maintain equal weight on points of pressure such as buttocks, shoulder blades, elbows, backs of knees and heels			
3. Assure there is adequate space between back of knee and chair—this will ensure no pressure is placed on the popliteal artery or nerve thus interfering with blood flow and nerve function			

4. Re-position student as ordered by physician or district policy			
5. Document procedure			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Feeding

The gastrointestinal system breaks down food into basic nutrients that feed the body. It is made up of organs that break down food into protein, vitamins, minerals, water, carbohydrates, and fats, which the body needs for energy, growth and repair. After food is chewed and swallowed, it goes down the esophagus and enters the stomach. Once in the stomach, it is further broken down by powerful stomach acids. From the stomach the food travels into the small intestine where the food is broken down further into nutrients that can enter the blood stream through tiny hair-like projections. The excess food the body doesn't need or can't digest is turned into waste and is eliminated from the body.

Some students have impaired feeding abilities for one or multiple reasons and may require assistance with oral feedings or may require feedings through a surgically inserted feeding tube. There are several types of feeding tubes. A gastrostomy is a surgical opening into the stomach through the surface of the abdomen. The gastrostomy tube (G-tube) is a flexible catheter held in place by a balloon or a widened flat "mushroom" at the tip of the tube inside the stomach. The tube remains in place at all times and is closed between feedings to prevent leakage of stomach contents. G-tubes cause no discomfort.

The G-tube may be used to administer food and fluids directly into the stomach. This method is used to bypass the usual route of feeding by mouth when

1. There is an obstruction of the esophagus.
2. Swallowing is impaired, and the student is at risk for choking/aspiration.
3. The student has difficulty taking enough food by mouth to maintain adequate nutrition.

A student may receive a G-tube feeding by either bolus or continuous (slow-drip) method. A bolus is a specific amount of feeding given at one time (over 20-30 minutes). A slow drip is a feeding that is given slowly over a number of hours, running continuously. The G-tube may be used to drain abdominal contents or to release air gas when venting is required. Tube feedings can usually be given in any setting where respect for the student's privacy can be observed. Those students who require venting or drainage procedure should be in a private setting. G-tubes are usually covered by clothing and should not hinder the student's ability to participate in regular school activities; however, the student may require a modification in physical activities.

The health assessment and creation of the Individual Health Care Plan will be performed by the school nurse in conjunction with the physician orders and parental guidance.

Procedure for bolus feeding—*Slow-drip method is in Italics where changes are appropriate*

1. Wash hands.
2. Gather equipment:
    a. Formula
    b. 60cc catheter tip syringe or other container for feeding
    c. Clamp or cap for end of tube

d. Water if prescribed
e. Rubber bands and safety pins
f. Gloves

3. Remove cap or plug from G-tube and insert catheter tip syringe into the end of the G-tube.
4. Unclamp tubing and gently draw back on the plunger to remove any liquid or medication that may remain in the stomach (this is called the residual). Note the amount and replace contents into the stomach. Refer to the student's record for correct procedure for recording the amount of residual.
5. Clamp the tubing, disconnect the syringe, and remove plunger from syringe.
    a. ***For <u>slow-drip method</u> pour formula into feeding bag and run feeding through bag and tubing to the tip and clamp***
    b. ***Hang bag on a pole at the height required to achieve prescribed flow. If a feeding pump is used, place tubing into pump mechanism and set for proper flow rate***
6. Reinsert catheter tip into tubing.
    a. ***For <u>slow-drip method</u> insert tip of feeding bag into G-tube, tape securely. Unclamp G-tube.—skip to #12***
7. Unclamp tube and allow bubbles to escape.
8. Pour room temperature feeding/fluid into syringe and allow to flow in by gravity.
9. Continue to pour formula into syringe as contents empty.
    a. ***<u>For continuous feeding</u> with pump, add more fluid when bag is empty***
    b. ***<u>For single feeding</u> when complete, clamp feeding bag tubing, clamp G-tube and disconnect bag from G-tube. Skip to # 15***
10. Raise or lower syringe to adjust flow to prescribed rate.
11. When feeding is complete pour prescribed amount of water into the syringe.
12. Vent tube if ordered.
13. Replace tube securely underneath clothing.
14. Remove gloves and wash hands and equipment.
15. DOCUMENT PROCEDURE

Procedure for **skin level** bolus feeding—*Slow-drip method is in italics where changes are appropriate*

1. Wash hands.
2. Assemble equipment:
    a. Formula
    b. 60cc catheter tipped syringe
        i. ***Feeding pump and IV stand (optional)***
    c. Adaptor with tubing and clamp
    d. Water if prescribed
    e. Gloves
3. Explain procedure to the student.
4. Position student to keep his/her head at a minimum of 30°.
5. Wash hands and put on gloves.
    a. ***Attach the adapter to the feeding tube bag—skip to #9***

6. Remove plunger from syringe and attach the adaptor to the feeding syringe.
7. Open safety plug from device and insert adaptor and tubing into device.
8. Clamp off tubing.
9. Pour feeding into syringe.
    a. ***Pour feeding/fluids into feeding bag and run feeding through bag and tubing to the tip. clamp***
10. Elevate syringe and unclamp tubing.
    a. ***Hang bag on pole at height required to achieve prescribed flow. If a feeding pump is used, place tubing into pump mechanism and set proper flow rate***
    b. ***Open safety plug and insert tubing into device***
    c. ***Open clamp only enough to adjust rate until drips flow at prescribed rate***
11. Continue to pour feeding into syringe as contents empty into stomach.
    a. ***For continuous feeding with pump, add more fluid to bag when empty***
    b. ***If single bolus feed, clamp bag when empty—skip to #13***
12. Raise or lower syringe or container to adjust flow as prescribed.
13. Flush tubing and device with water if ordered.
14. When feeding is complete, remove the adaptor with feeding syringe.
15. Close safety plug.
16. Remove gloves and wash hands and equipment.
17. DOCUMENT PROCEDURE

Possible problems

1. If you notice color changes/ breathing difficulties with the student—***STOP FEEDING IMMEDIATELY***—*this may be due to aspiration of fluid. Call school nurse if he/she is not present. Refer to the student specific emergency plan.*
2. Nausea and or cramping.
    a. Check rate of feeding—may need to slow it down
    b. Check temperature of formula—needs to be room temperature
3. Vomiting.
    a. If all of the above have been checked, STOP FEEDING and call school nurse & family
4. Blocked gastrostomy device.
    a. May be due to inadequate flushing or very thick fluid. Flush with warm water after feeding or medication. If problem persists call family
5. Bleeding, drainage, redness, irritation.
    a. Check skin around gastrostomy device site daily. Clean stoma site if leakage of fluid, food or medication comes into contact with skin.
    b. Refer to student specific guidelines for cleaning
    c. Rotate device 360 degrees with each cleaning
    d. Dry stoma and surrounding skin well; leave area open to air to facilitate drying
6. Leaking stomach contents.
    a. May be due to a problem with the anti-reflux valve. Clean skin and notify family
7. Gastrostomy device falls out.

a. THIS IS **NOT** AN EMERGENCY—Save the device in clean gauze or container for reinsertion. In some students, whose tracts may close quickly, the gastrostomy device may need to be reinserted within 1-2 hours. Cover gastrostomy site with bandage or clean dressing. Contact family and school nurse.

Nutritional Assessment (ASBN 1.6.1)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Oral Feeding (ASBN 1.6.2)

School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Wash hands			
2. Assure the student has the appropriate and correct diet			
3. Prepare tray: open cartons, remove lids, cut food			
4. If the student is able to eat independently, allow student to feed self			
5. For the student who cannot eat independently, assist with feeding			
a. Sit in a comfortable position			
b. Ask the student which food he/she would like to eat first			
6. Feed student in a manner which promotes chewing and swallowing: give small bites and allow ample time			
7. Provide liquids as requested			
8. Talk with the student			
9. Use this opportunity to talk about good nutrition habits			
10. Assist with hand washing			
11. Document procedure			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Naso-Gastric Feeding (ASBN 1.6.3)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Monitoring N/G Feeding (ASBN 1.6.4)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Gastrostomy Feeding (ASBN 1.6.5) **Bolus Method** School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify students' ability to participate in procedure			
2. Review universal precautions			
3. Complete at feeding's at_____am/pm			
4. _____cc (amount) _____formula/feeding (type)			
5. Feeding to be completed in _____minutes			
6. Position for feeding _____			
7. Identify possible problems and appropriate actions			
Supplies			
1. Catheter _____(size) _____type			
2. Balloon size _____cc			
a. Small port plug			
b. Feeding port			
3. Gloves			
4. Formula at room temperature			
5. Clamp and plug			
6. Tap water, if prescribed			
7. Rubber bands and safety pins if needed			
Procedure			
1. Wash hands			
2. Gather supplies			
3. Position student and explain procedure			
4. 60-cc catheter-tipped syringe			
5. Wash hands and apply gloves			
Student Specific: steps 6-12 need to be individualized for each student			
6. Check for proper placement of tube: attach syringe and aspirate stomach contents by pulling plunger back			
7. Measure content			
8. Return stomach contents to stomach			
9. If stomach contents are over _____cc, subtract from feeding			
10. If more than _____cc, hold feeding			
11. Pinch or clamp off tube			
12. Remove syringe			
13. Attach syringe without plunger to feeding port			
14. Pour formula (room temp) into syringe (approx 30-40cc)			

15. Release or unclamp tube and allow feeding to go in slowly			
16. Lower the syringe if feeding is going too fast			
17. When feeding gets to 5-cc mark, add more formula			
18. Continue this procedure until the feeding has been completed			
19. Make feeding a pleasant time for the student			
20. Flush tube with _____cc of water when feeding is complete			
21. Vent G-tube ,if ordered			
22. Pinch off tubing, remove syringe, and close clamp			
23. Apply dressing if needed			
24. Clean feeding equipment			
25. Wash hands			
26. Document Procedure			
27. Report any changes or concerns to RN			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Gastrostomy Feeding (ASBN 1.6.5) **Slow-Drip or Continuous Method**

School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
8. Identify student's ability to participate in procedure			
9. Review universal precautions			
10. Complete feeding(s) at _____am/pm			
11. _____cc (amount) _____formula/feeding (type)			
12. Feeding to be completed in _____minutes			
13. Position for feeding _____			
14. Identify possible problems and appropriate actions			
Supplies			
8. Catheter _____(size) _____type			
9. Balloon size _____cc			
c. Small port plug			
d. Feeding port			
10. Gloves			
11. Formula at room temperature			
12. 60cc catheter tip syringe			
13. Pump and IV stand (if used)			
14. Clamp and plug			
15. Tap water, if prescribed			
16. Rubber bands and safety pins, if needed			
Procedure			
28. Wash hands			
29. Gather supplies			
30. Position student and explain procedure			
31. 60-cc catheter-tipped syringe			
32. Wash hands and put on gloves			
Student Specific: steps 6-11 need to be individualized for each student			
33. Check for proper placement of tube: attach syringe and aspirate stomach contents by pulling plunger back			
34. Measure contents			
35. Return stomach contents to stomach			
36. If stomach contents are over _____cc, subtract from feeding			
37. If more than _____cc, hold feeding			

38. Pinch or clamp off tube			
39. Pour feeding/fluids into feeding container, run feeding through tubing to the tip and clamp tubing			
40. Hang container on pole at height required to deliver prescribed flow; if pump is used, set the flow rate			
41. Open plug and insert tubing into the tube			
42. Open clamp on tubing and adjust flow to prescribed rate (if using a pump—open the clamp completely)			
43. When a single feeding is complete, clamp tubing and G-tube and disconnect			
44. Make feeding a pleasant time for the student			
45. Attach catheter tipped syringe with plunger removed and flush with _____cc of water as ordered.			
46. Vent G-tube if ordered			
47. Clamp G-tube			
48. Apply dressing if needed			
49. Clean feeding equipment			
50. Wash hands			
51. Document Procedure			
52. Report any changes or concerns to RN			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Gastrostomy Feeding (ASBN 1.6.5) **Slow-Drip or Continuous Method**

School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
15. Identify students ability to participate in procedure			
16. Review universal precautions			
17. Complete at feeding(s) at_____am/pm			
18. _____cc (amount) _____formula/feeding (type)			
19. Feeding to be completed in _____minutes			
20. Position for feeding _____			
21. Identify possible problems and appropriate actions			
Supplies			
17. Size and type of gastrostomy device_____			
18. Gloves			
19. Formula at room temperature			
20. 60cc catheter tip feeding syringe			
21. Pump and IV stand (if used)			
22. Adapter with tubing			
23. Tap water, if prescribed			
Procedure			
53. Wash hands			
54. Gather supplies			
55. Position student and explain procedure			
56. Remove the plunger from a 60-cc catheter-tip syringe			
57. Attach the adapter to feeding syringe			
58. Safely open plug and attach the adaptor and tubing with feeding syringe to the skin level device			
59. Clamp or pinch off tubing and pour feeding to about half full			
60. Elevate the feeding above the stomach a. open clamp b. allow feed to go in slowly			
61. Do not allow syringe to become empty. Refill the syringe with feeding until all is complete.			
62. Make feeding a pleasant time for the student			
63. Flush with _____cc of water as ordered			
64. Lower syringe to level of the stomach to allow burping			

65. Remove feeding tubing and clamp G-tube			
66. Apply dressing, if needed			
67. Clean feeding equipment			
68. Wash hands			
69. Document Procedure			
70. Report any changes or concerns to RN			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Gastrostomy Feeding (ASBN 1.6.5) **Skin level Slow-Drip or Continuous Method**

School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
22. Identify student's ability to participate in procedure			
23. Review universal precautions			
24. Complete feeding(s) at _____am/pm			
25. _____cc (amount) _____formula/feeding (type)			
26. Feeding to be completed in _____minutes			
27. Position for feeding _____			
28. Identify possible problems and appropriate actions			
Supplies			
24. Size and type of gastrostomy device_____			
25. Gloves			
26. Formula at room temperature			
27. 60cc catheter tip feeding syringe			
28. Pump and IV stand (if used)			
29. Adapter with tubing			
30. Tap water, if prescribed			
31. Pole to hold feeding container			
Procedure			
71. Wash hands			
72. Gather supplies			
73. Position student and explain procedure			
74. Remove plunger from 60-cc catheter-tip syringe			
75. Attach the adapter to feeding syringe without plunger			
76. Pour feeding /fluids into feeding container, run feeding through tubing to the tip, clamp tubing			
77. Hang container on pole at height required to deliver prescribed flow (if pump is used, place tubing into pump and set flow rate)			
78. Open clamp on tubing and adjust flow to prescribed rate (if pump is used open clamp completely)			
79. For continuous feeding evaluate rate and flow periodically and adjust if needed			
80. When single feeding is completed, clamp feeding bag tubing and remove			
81. Make feeding a pleasant time for the student			
82. Attach catheter-tip syringe then flush tubing and feeding device			

83. Lower syringe to below level of the stomach to allow burping			
84. Remove adapter and tubing then clamp safety plug in place			
85. Clean feeding equipment			
86. Wash hands			
87. Document Procedure			
88. Report any changes or concerns to RN			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Monitoring Gastrostomy Feeding (ASBN 1.6.6) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Things to watch for with gastrostomy tube feedings			
1. Changes in skin color, breathing, difficulties—STOP FEEDING IMMEDIATELY			
2. Nausea/ vomiting			
a. Check flow rate			
b. Check temperature of formula			
3. Vomiting			
a. If above items have been checked—STOP FEEDING			
4. Blocked gastrostomy device			
a. Flush with warm water after feeding or medication administration			
5. Bleeding, drainage, skin redness and/or irritation			
a. Check skin daily			
b. Refer to student emergency plan			
c. Rotate device in complete circle (360 degrees) with cleaning			
d. Dry stoma well			
6. Leaking of the stoma			
a. Clean skin and notify RN and family			
7. Gastrostomy device falls out—THIS IS ***NOT*** AN EMERGENCY			
a. Save device			
b. Contact RN and family			
8. Document procedure			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Jejunostomy Tube Feeding (ASBN 1.6.7)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Total Parenteral Feeding (ASBN 1.6.8)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Monitoring Parenteral Feeding (ASBN 1.6.9)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Naso-Gastric Tube Feeding (ASBN 1.6.10)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Naso-Gastric Tube Removal (ASBN 1.6.11) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Put on gloves			
2. Remove adhesive from the nose, discontinue suction			
3. Grasp NG tube at the nose			
4. Gently pull until the entire tube is removed			
*Note: look at the integrity of the tube—is the tube intact or has it been broken?			
5. Notify RN immediately if the NG tube has been emergently removed			
6. DOCUMENT PROCEDURE			
a. Explain the situation immediately prior to removal of the tube			
b. Explain why the NG tube was removed			
c. Explain actions taken			
d. Note condition of the tube looked after removal			
Indications for Emergent Removal of the NG tube			
1. Student specific information to be filled in by RN in conjunction with Physician orders and family wishes.			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Gastrostomy Tube Reinsertion (ASBN 1.6.12)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Section VI

Urinary Catheterization

Urinary System

The urinary system eliminates waste from the body in the form of urine. The kidneys remove waste from the blood. They are two fist-sized organs, one on each side of the spine at the back of the upper abdomen, that regulate the amount of water in the body. Most of the water filtered from the blood, through the kidneys is recycled back to the body. The kidneys also regulate blood pressure, growth, calcium absorption, and red blood cell production.

The blood vessels include renal arteries that carry blood from the main artery to the kidneys, where waste is filtered out, and the renal veins that take cleansed blood away from the kidneys. The waste combines with water to form urine. From the kidneys, urine travels down two thin tubes called ureters to the bladder. The bladder is a reservoir for storing the urine until it is ready to be discharged from the body. When the bladder is full, urine is discharged through the urethra. The urethra is a tube leading from the bladder to the outside opening (meatus) of the body through which urine is discharged. In girls, the meatus is located between the labia, just above the vagina and in boys, it is at the tip of the penis.

Some students may have urinary system impairments due to disease processes or structural abnormalities. These students may require a procedure called a clean intermittent catheterization (CIC). CIC helps prevent urinary tract infections in students who have difficulty emptying their bladders. When the bladder remains filled with stagnant urine for long periods of time, rapid bacterial growth occurs and infection may result. Catheterizing the bladder every few hours eliminates urine before bacteria can multiply to cause an infection. CIC also prevents wetting caused by overflow incontinence, a condition in which urine overflows the bladder and dribbles out the urethra.

CIC is often used when the nerves that stimulate the bladder do not function properly. For instance, a condition called *neurogenic bladder* is associated with Spina Bifida and other conditions in which the nerves from the spinal cord to the bladder are damaged, such as with spinal cord injuries. Because of nerve damage, the bladder is completely or partially unable to empty, which can lead to an increased risk of infection, possible backup of urine to the kidneys resulting in kidney damage, and incontinence.

CIC may be performed in an area where the student has privacy if he/she performs the procedure. If the unlicensed assistive person is to perform the task, make sure the area is easily accessible and proper body mechanics are utilized.

CIC Procedure Male and *Female (changes to accommodate the female will be italicized)*

1. Wash hands.
2. Gather supplies:
    a. Water soluble lubricant
    b. Catheter
    c. Wet wipes or cotton balls
    d. Storage receptacle for catheter
    e. Container for urine or toilet
    f. Gloves
3. Explain the procedure to the student.
4. Position the student.
5. Wash hands and put on gloves.
6. Show the student, depending on age, the location of the urethral opening.
    a. For a female you can use a mirror to show the opening
7. Lubricate the tip of the catheter and place on a clean surface.
8. Cleanse the penis by holding below the glans at a 45° angle from the abdomen depending on the position of the student or student specific guidelines and retract foreskin if not circumcised. Wash the glans with soapy cotton balls or student-specific cleansing supplies. Begin at the urethral opening, and in a circular manner, wash away from the meatus. Repeat twice for a total of three washings. Use clean cotton balls each time.
    a. Female: separate the labia and hold open with fingers. Cleanse in a top-to bottom direction from the top of the labia toward the rectum. Wash three times: once down each side and once down the middle.
9. Hold the penis at a 45° angle from the abdomen depending on the position of the student or student specific guidelines. Insert catheter gently into the urethral opening. Some resistance may be met at the bladder sphincter. Use gentle but firm pressure until the sphincter relaxes. Encouraging the child to relax may be helpful.
    a. Female: locate the urinary meatus (opening). Gently insert the catheter until there is urine.
10. Insert the catheter until there is a good flow of urine. When the flow stops, insert catheter slightly more and then withdraw a little to make sure all urine is drained. Rotate catheter so catheter openings have reached all areas of the bladder.
11. When the bladder has emptied, pinch catheter and withdraw.
    a. Female skip to #13
12. If the student is not circumcised, pull the foreskin over the glans when finished.
13. Remove gloves and wash hands.
14. Assist student in dressing.
15. Put on gloves.
16. Measure and record the urine volume if ordered. Dispose of urine, clean equipment, and store in appropriate container.
17. Wash hands.

18. DOCUMENT PROCEDURE.

Possible Problems which require Immediate Attention

1. Bleeding from the urethra—this may be due to trauma to the urethra or a urinary tract infection. STOP THE CATHETERIZATION and call the RN.
2. Inability to pass catheter.
    a. May be due to increased sphincter tone caused by anxiety or spasm. Encourage the child to relax.
    b. For boys: reposition the penis and use gentle but firm pressure until the sphincter relaxes. Sometimes is may be helpful to have boys flex at the hips to decrease reflex resistance of the bladder sphincter.
    c. For girls: check catheter placement. The catheter may be in the vagina. If catheter is in the vagina, do not reinsert; use a clean catheter.
    d. If unsuccessful, notify RN for further instructions.
3. No urine as a result of catheterization—this may be due to improper placement of catheter or the bladder may be empty. Check position of the catheter.
4. Cloudy urine, mucus, foul odor, color changes, or unusual wetting between catheterizations—this may be due to a urinary tract infection. Always report to the RN any changes in the student's usual pattern or tolerance of procedure.

Clean Intermittent Catheterization—Male (ASBN 2.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify student's ability to participate in procedure			
2. Review universal precautions			
3. Catheterizations will occur at _____times(s)—In an emergency this procedure will be completed earlier rather than later			
4. Procedure will be completed in an area which provides the most privacy for the student			
5. Position for catheterization_____			
6. Identify possible problems and appropriate actions			
Supplies			
1. Water soluble lubricant			
2. Type of catheter _____			
3. Wet wipes or cotton balls			
4. Cleansing supplies			
5. Storage receptacle for catheter			
6. Container for urine			
7. Gloves			
Procedure			
1. Wash hands			
2. Gather equipment			
3. Arrange equipment for procedure (having equipment prepared prior to procedure reduces anxiety of the student			
4. Cleansing supplies			
5. Wash hands and put on gloves			
6. Lubricate catheter and place on clean surface			
7. Cleaning procedures:			
a. Prepare cleaning materials			
b. Retract foreskin if necessary			
c. Pull penis forward in a straight motion and hold at a 45° angle from the abdomen			
d. Clean the meatus and glans			
e. Use each swab only once			
f. Wipe a minimum of three times			
8. Catheterization procedure:			
a. Grasp catheter about 4 inches from the tip			

b. Insert well lubricated catheter into penis with consistent pressure (if muscle spasm occurs, stop momentarily and then again use slow even pressure) NEVER FORCE A CATHETER.			
c. When urine flow stops, insert slightly more and withdraw slightly			
d. Rotate catheter so all catheter openings allow for bladder to empty completely			
e. Allow urine to flow by gravity into the shallow pan or toilet			
Student specific (Steps 13-15 need to individualized for each student)			
f. If ordered, gently press bladder to help empty			
g. Pinch catheter and withdraw slowly when urine stops flowing			
h. If not circumcised, pull foreskin over glans			
i. Remove gloves and wash hands			
j. Assist student in dressing			
k. Put on gloves, measure and record amount of urine collected, clean materials and replace			
l. Wash hands			
m. Document procedure and observations			
n. Notify RN of any changes or concerns			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Clean Intermittent Catheterization—Female (ASBN 2.1)School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Preparation			
1. Identify student's ability to participate in procedure			
2. Review universal precautions			
3. Procedure will be completed in an area which provides the most privacy for the student			
4. Position for catheterization_____			
5. Identify possible problems and appropriate actions			
6. Supplies			
7. Water soluble lubricant			
8. Type of catheter _____			
9. Wet wipes or cotton balls			
10. Cleansing supplies			
11. Storage receptacle for catheter			
12. Container for urine			
13. Gloves			
14. Mirror			
15. Procedure			
16. Wash hands			
17. Gather equipment			
18. Arrange equipment for procedure (having equipment prepared prior to procedure reduces anxiety of the student			
19. Cleansing supplies			
20. Wash hands and put on gloves			
21. Lubricate catheter and place on clean surface			
22. Cleaning procedures:			
23. Prepare cleaning materials			
24. Open labia minora and majora			
25. Clean from front of folds to back of meatus			
26. Use swab only once			
27. Wipe a minimum of three times			
28. Catheterization procedure:			
29. Grasp catheter about 3 inches from the tip			
30. Insert well lubricated catheter into urethra until urine begins to flow NEVER FORCE A CATHETER.			
31. Advance ½ inch more			

32. Rotate catheter so all catheter openings and allow for complete bladder emptying			
33. Allow urine to flow by gravity into the shallow pan or toilet			
34. Student specific (Steps 13-15 need to individualized for each student)			
35. If ordered, gently press bladder to help empty			
36. Pinch catheter and withdraw slowly when urine stops flowing			
37. If urine begins to flow again during removal—Wait until all urine has stopped flowing to remove catheter			
38. Remove gloves and wash hands			
39. Assist student in dressing			
40. Put on gloves, measure and record amount of urine collected, clean materials and replace			
41. Wash hands			
42. Document procedure and observations			
43. Notify RN of any changes or concerns			

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

Section VII

Medical Support Systems

Ventricular Peritoneal Shunt Monitoring

The brain is a complex network of nerve cells and is responsible for all actions which maintain and support life. The brain also contains hollow spaces called ventricles which produce a substance called cerebrospinal fluid (CSF). This fluid acts as a cushion for the brain and supplies nutrients to the brain. Normally some of this CSF stays around the brain and spinal cord in a compartment called the subarachnoid space. The brain must always have a continuous balance in the amount of fluid that remains around the brain and the amount that is circulated.

Sometimes there is a backup of this fluid into the ventricle which puts pressure on the brain. This is called hydrocephalus. When this occurs, a shunt system is surgically placed. The shunt system redirects the flow of CSF from the brain to another area of the body where it can be absorbed. When cerebrospinal fluid is redirected from a blocked ventricle to the peritoneal area of the abdominal cavity, it is called a ventriculoperitoneal shunt. A shunt is a soft, flexible, but sturdy tube that is well-tolerated by normal body tissues. One end of the catheter is placed within a ventricle inside the brain and the other end of the catheter is placed within the peritoneal (abdominal) cavity. A valve located along the catheter maintains one-way flow and regulates the rate of CSF flow. The placement of a VP-shunt is a surgical procedure that is performed by a neurosurgeon. A shunt may be temporary or permanent. Sometimes a shunt may need to be replaced or revised if it is not working properly.

Some key elements to watch for when caring for a student who has a VP-shunt are

1. Headache
2. Vomiting
3. Vision difficulties
4. Confusion
5. Fever higher than 101.5 orally (check temperature before taking Tylenol)
6. Increased redness or discomfort or new or excessive drainage from an incision or wound from a recent shunt placement/revision
7. Increased sleepiness

If any of the above mentioned items occurs NOTIFY THE RN IMMEDIATELY.

Adapted from the Jefferson Hospital Department of Neurosurgery Ventriculoperitoneal shunt patient handout.

Ventricular Peritoneal Shunt Monitoring (ASBN 3.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Watch for the following symptoms.			
***** If any occur NOTIFY THE RN IMMEDIATELY*****			
1. Headache			
2. Vomiting			
3. Trouble seeing			
4. Confusion			
5. Fever greater than 101.5 orally			
6. Increased redness or discomfort or new or excessive drainage from an incision site from a new shunt placement/revision.			
7. Increased sleepiness			
8. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Mechanical Ventilator

Some students may require mechanical ventilation. Some disease processes and respiratory system abnormalities cause individuals to require mechanical ventilation. This section may be tedious; however, it is crucial for the unlicensed assistive personnel to understand the terminology associated with ventilators in order to notify the RN of problems.

Important terms to understand

1. **Respiratory rate**: the number of times an individual breathes every minute.
2. **Tidal Volume**: how much air is taken into the lungs with each breath (how big the breath is).
3. **Continuous Mandatory Ventilation (CMV)**: provides continuous ventilation for an individual by providing the rate of breaths per minute as well as tidal volume.
4. **Synchronized Intermittent Mandatory Ventilation (SIMV):** the machine is set to correlate with the individual's spontaneous breathing so that the ventilator and the person don't compete.
5. **Pressure Support ventilation**: this mode is to assist the individual with their own breathing. The person does all the work to breathe in and out. The machine only provides pressure to help make the initial breathing in process easier. **With this mode of ventilation it is important to monitor for periods of apnea (a pause in breathing lasting several seconds) and respiratory fatigue.
6. **Positive end-expiratory pressure (PEEP)**: this is used to increase oxygenation by providing pressure into the lungs when all the air has been expelled from the lungs. This allows for more oxygen exchange to occur in the small openings called alveoli.
7. **Continuous positive airway pressure (CPAP)**: this is used to keep the airways open during inspiration. This increases oxygenation just like PEEP.

Monitoring the ventilator

It is important to understand the terms described above because the ventilator has many settings which are set to alarm if a value goes out of the acceptable range. During the course of caring for a student on a ventilator an alarm may sound. It is important to stay calm and troubleshoot the problem. Below are some terms one may see, possible causes and possible solutions.

1. **High pressure alarm**
    a. Causes: coughing, blocked tracheostomy tube, sneezing, talking, laughing, crying, hiccups, holding breath, changes in position or a kinked ventilator tubing
    b. Solutions: Suction if needed, reposition student. If these interventions do not correct the alarm, disconnect patient from the ventilator and use the AMBU bag. If the student is OK then check the ventilator tubing for kinks or water, blocked exhalation valve, or an accidental change in the ventilator setting. Once the problem has been corrected place the student back on the ventilator

    Note: a second staff member may need to provide ventilator support with the AMBU bag while one staff member trouble shoots the ventilator
2. **Low pressure alarm**

a. Causes: student has become disconnected from the ventilator or there is a leak in the ventilator tubing.
b. Solutions: remove student from ventilator and gives breath with the AMBU bag. If the student is OK then check for disconnected tubing, kinked tubing, punctured tubing, water or a hole in the exhalation valve, loose-fitting heater humidification source, check all ventilator settings. Test the system after a leak is found by occluding student end of the circuit and wait for the high pressure alarm to sound.

Note: a second staff member may need to provide ventilator support with the AMBU bag while one staff member trouble shoots the ventilator

3. **Power source alarm**
    a. Cause: loss of power from a power source
    b. Solution: check the AC powe, check the internal and external batteries.

When using manual ventilation with the AMBU bag for more than 15 minutes, add drops of saline through the tracheostomy tube for humidity or use the passive condenser with the resuscitator bag. ALWAYS FOLLOW THE EMERGENCY PLAN AND NOTIFY THE RN IF AN ALARM OCCURS.

Ambu bag

An Ambu bag is also known as a bag-valve-mask. This device is used to provide positive pressure ventilation to an individual who is not breathing or not breathing well. The bag has an air chamber that is squeezed in order to force air into the lungs of the student. When the bag is released, it re-inflates pulling oxygen back into the chamber. The bag can be used by itself or with oxygen depending on the needs of the student.

1. Apply gloves.
2. Ensure the student is free from secretions before using the bag.
3. Connect the bag to the tracheostomy collar connector (these should remain connected in case of an emergency).
4. Connect the oxygen tubing to the bag. Be sure the tubing is connected to the regulator on the oxygen tank, the oxygen tank is turned on, and the regulator is at the flow rate prescribed by the physician.
5. Connect the bag to the tracheostomy tube keeping the bag at a 90° angle. Squeeze the bag in coordination with the student's own breathing.
6. When appropriate remove the bag from the tracheostomy tube.
7. Wash hands
8. DOCUMENT PROCEDURE

Oxygen

Some students may require oxygen during the school day. Oxygen therapy is used to keep the student from becoming hypoxic. Hypoxia is a condition where not enough oxygen is available in the body to meet all of

the demands of normal metabolism within the body. Therefore, a supplemental oxygen supply must be provided. Certain disease processes require the use of oxygen to correct oxygenation problems.

Guidelines for the use of oxygen

1. Oxygen is considered a medication and must NOT be altered without an order from a physician.
2. When oxygen is in use a sign stating "Oxygen in use" MUST be placed on each entry into the classroom.
3. Oxygen must be stored a minimum of 10 feet from an open flame.
4. When in use, oxygen cylinders must be kept upright and secured so they do not fall over.
5. Always make sure electrical equipment in the room works properly.
6. Check the level of the portable oxygen tanks before any event which requires the student to be away from a back-up source of oxygen.

Intermittent oxygen therapy

Follow the guidelines stated in the student specific Healthcare plan.

Continuous Oxygen Monitoring

Things to watch for in the student who is on oxygen therapy

1. Anxiety, apprehension or behavior change.
2. Increased heart rate.
3. Increased respiratory rate and depth of respirations becomes irregular.
4. Difficulty breathing.
5. Use of accessory muscles for respirations (nasal flaring, rib retractions and tracheal tugging).
6. Dizziness.
7. Changes in color: the student becomes cyanotic (blue or grey looking).

IF ANY OF THESE SYMPTOMS OCCUR NOTIFY THE RN IMMEDIATELY AND FOLLOW THE EMERGENCY PROCEDURE

Mechanical Ventilator Monitoring (ASBN 3.2.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Ventilator Machine and Circuit			
1. Locate the power source			
a. Internal battery			
b. External battery			
c. Accessible and grounded functioning electrical outlets			
d. Back-up battery			
e. Emergency power supply			
2. Oxygen source (if needed)			
a. Connection to ventilator and spare tubing			
b. Oxygen supply, spare tank, and gauge			
c. Flow (LPM-Liters per minute) and percentage of oxygen			
3. Humidification source			
a. Passive condenser			
4. Volume			
5. Rate			
6. Patient pressure manometer			
7. Peak inspiratory pressure (PIP)			
8. Positive end expiratory pressure (PEEP)			
9. Ventilator mode			
10. Inspiratory time			
11. High-Pressure alarm			
12. Low-Pressure alarm			
13. Power Source alarm			
14. Describe: patient pressure tubing, patient port, exhalation valve PEEP value and additional adaptors			
GO BAG Supplies			
1. AMBU bag with adaptor or mask			
2. Spare tracheostomy tube and supplies			
3. Suctioning supplies			
Ventilator Troubleshooting Alarms			
1. Identify which alarm is sounding			
2. ***Low-Pressure* Alarm** Check student first, then:			
3. Remove the student from the ventilator and give breaths with AMBU bag			
4. If the student is OK, then check for leaks.			
a. Student disconnected?			

b. Disconnected tubing?			
c. Kinked tubing?			
d. Punctured tubing?			
e. Water in exhalation valve?			
f. Hole in exhalation valve?			
g. Loose-fitting heater humidification source?			
h. Check ventilator settings?			
5. Test system after leak is found (occlude student end of circuit and wait for high-pressure alarm to sound).			
6. Return student back to ventilator			
7. ***High Pressure Alarm*** Checks student first, then:			
8. Check activity of student			
a. Needs suctioning?			
b. Blocked tracheostomy tube			
c. Coughing? Sneezing? Talking? Crying? Laughing? Hiccups?			
d. Body position?			
e. Holding breath?			
9. Suction if needed			
10. Realign or change tracheostomy tube, if needed			
11. Remove student from ventilator and give breaths with AMBU bag			
12. If student is OK, then Check ventilator for obstructions			
a. Kinks in tubing?			
b. Water in tubing?			
c. Blocked exhalation valve?			
d. Accidental change in ventilator settings			
13. After solving problem and checking high-pressure circuit, return student to ventilator.			
14. ***Power Source Alarm*** Check student first, then:			
a. AC power?			
b. Internal battery?			
c. External battery?			
d. Remove student from ventilator if all three systems fail and give breaths with AMBU bag			
e. If bagging is required for more than 15 minutes, add drops of saline to the tracheostomy for humidity or puts passive condenser on resuscitation bag and continue to bag the student			
f. FOLLOW THE STUDENT SPECIFIC EMERGENCY PLAN			
g. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Adjustment of Ventilator (ASBN 3.2.2)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, this task MUST be performed by a licensed individual.

Ambu Bag (ASBN 3.2.3) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
AMBU Bag with Tracheostomy			
1. Identify student's ability to participate in the procedure			
2. Review universal precautions			
3. Supplies:			
a. Oxygen source with appropriate tubing if needed			
b. Manual resuscitator			
c. Adaptor for tracheostomy tube			
d. Go-Bag items			
4. Wash hands			
5. Position student and explain procedure			
6. Checks that AMBU bag is functioning properly			
7. Attach AMBU bag to tracheostomy tube			
8. Coordinate manual breaths with student's own breaths, if student breathes independently			
9. If student is unable to breathe independently, squeeze AMBU bag at regular rate to give prescribed breaths per minute			
10. Remove AMBU bag from tracheostomy tube when appropriate			
11. Report any changes to RN Immediately			
12. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Oxygen—Intermittent (ASBN 3.3.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Use this form to create a student-specific plan for Intermittent Oxygen			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Oxygen—Continuous Monitoring (ASBN 3.3.2) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
1. Anxiety, apprehension or behavior change			
2. Increased heart rate			
3. Increased respiratory rate and depth of respirations becomes irregular			
4. Difficulty breathing			
5. Use of accessory muscles for respirations (nasal flaring, rib retractions and tracheal tugging).			
6. Dizziness			
7. Changes in color: the student becomes cyanotic (blue or grey looking)			
NOTIFY RN IF ANY OF THESE SYMPTOMS ARE NOTICED			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Central Line Catheter (ASBN 3.4)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines this task MUST be performed by a licensed individual.

Peritoneal Dialysis (ASBN 3.5)

DO NOT DELEGATE

According to the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines this task MUST be performed by a licensed individual.

Section VIII

Medication Administration

Medication Administration

The delegation chapter of the Arkansas State Board of Nursing Rules lists medication administration as a task that shall not be delegated to unlicensed persons. It is recognized that in the school, camp, or day care center and juvenile detention center settings, the patient/client condition is generally stable, on routine or occasional as needed medications and the parent would medicate them in the same manner, if the parent were present. The licensed school nurse is responsible for the administration of medications. During times when the school nurse is not present, the administration of medications may be delegated to persons identified in the table for delegating specific tasks. A provider order and/or written permission from the parent/guardian must be on file for all medication administered "in loco parentis," in the place of the parent.

The licensed nurse is responsible for identifying qualified persons to be trained to administer medication in the nurse's absence. After training and documentation of the unlicensed person's competency, administering medications may be delegated as indicated in the nursing task chart and following the Principle's of Delegation and the Five Rights of Delegation.

Each facility (school, camp, day care center, juvenile detention center, etc.) shall have a written policy regarding the administration of medication. The policy should include at least the following:

1. A provider order is required for all prescription medications. A label on a prescription bottle may serve as the prescription, if acceptable to the facility.
2. Written parental permission is on file for all over the counter medications that are to be taken by the minor. Permission slips may be time limited, such as, the school year, a semester, one month, ore one week, depending on the governing body policy.
3. All medications must be in the original container.
4. The container must specify storage instructions if appropriate (insulin needs to be refrigerated).
5. Prescription medications are to be labeled with the student's legal name (on record with the facility), date prescription was filled, name of ordering provider name, name of medication, dose, route, and frequency.
6. All medications will be given according to label directions on the container. Deviations from label directions will require a written provider order.
7. Procedure for administering and documenting medications during field trips and extracurricular activities.
8. Documentation methods for the receipt of medication and the administration of medication.
9. Methods by which the nurse will receive mediation e.g., students may bring medication in with written authorization from parent/guardian or parent is required to deliver. medication to the school nurse.
10. Storage and security of medications.
11. Access to medications in the absence of the school nurse.
12. Accountability methods for controlled substances.
13. Arkansas Department of Health—Pharmacy Services Rules requires controlled substances to be kept under a double lock system
14. Nurses must establish a counting system to document the number of doses of a controlled substance brought to the school, such as counting the number of doses at the time they are delivered by the parent or student in the presence of the parent or student. Both must document the number delivered to the school. A count should be done periodically to verify the medication can be accounted for by documentation and the number on hand for the specific student. Access to controlled substances is to be limited to as few personnel as possible. The licensed nurse is to access and administer controlled substances.

In addition, the policy may specify the following

1. A requirement that the initial dose of a new medication must be given by the parent/guardian outside of the facility setting. A specific length of time may be required between the initial dose being given and the student's re-admittance to the facility.
2. Reports to parents/guardians regarding medication administration.
3. Parents/guardians are encouraged to administer medication at home whenever possible.

Disposal of unused medications:

1. Unused controlled substances that cannot be returned to the person for whom they are prescribed are to be sent to Pharmacy Services at the Arkansas Department of Health for destruction.
2. A surrender form can be obtained from Pharmacy Services at 501-661-2325.
3. Large quantities of non-controlled substances can also be sent to Pharmacy Services for destruction.
4. NOTE: It is NOT recommended that medications be flushed through the sewer system. There have been multiple studies which show the cleaning and filtration systems are not able to remove all particles of medications.

This section excerpted from the Arkansas State Board of Nursing School Nurse Roles & Responsibilities Practice Guidelines, Revised September 2007

Administering oral medications

1. Assemble needed supplies (cup, water, Medication Administration Record).
2. Verify child's ability to take oral medications.
3. Verify accuracy of medication:
    a. Right name
    b. Right medication
    c. Right dose
    d. Right time
    e. Right route
4. Prepare the medication.

Note: some medications may be crushed or broken if student has difficulty swallowing whole pills; however, the RN must verify the medication properties allow this

5. If the medication is in liquid form, be sure to shake the medication well to mix.
6. Cover the label of the bottle with the palm of the hand so the label is not destroyed after several administrations of the medication.
7. Administer the medication to the student. Assure the medication has been swallowed by looking into the mouth and under the tongue after the child has taken the medication.
8. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date
    b. Time
    c. Name of medication
    d. Who gave the medication

Administering over-the-counter medications

1. Follow the procedure listed above for administration.
2. Administer the medication EXACTLY AS DIRECTED on the container.
3. There MUST be a parent signature on the medication administration record.
4. Over-the-counter medications MUST be in the original packaging.
5. Under NO circumstances will medications be accepted in a plastic bag. Medications in a push-through container must be in the original packing container.

EpiPen ®Allergy Kit—EpiPen® and EpiPen® Jr

Initiate the Emergency Response by calling 9-1-1 if an EpiPen ® must be used

1. Pull off gray activation cap.
2. Grasp the injector with a fist around the barrel. NEVER place thumb over the black tip.
3. Hold black tip near outer thigh (always apply to thigh).
4. Swing and jab firmly into outer thigh until Auto-Injector mechanism functions. Hold in place and count to 10. Remove the EpiPen ®.

Twinject® 0.3 mg and Twinject® 0.15mg

1. Remove caps labeled “1” and “2”
2. Grasp the injector with a fist around the barrel. NEVER place thumb over the black tip.
3. Place rounded tip against outer thigh, press down hard until needle penetrates the skin. Hold for 10 seconds, and then remove.

Second dose administration:

4. Unscrew rounded tip. Pull syringe from barrel by holding blue collar at needle base.
5. Slide yellow collar off plunger.
6. Put needle into thigh through the skin, push the plunger down all the way and remove.

Keep the used unit with the student.

1. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date

b. Time

c. Name of medication

d. Who gave the medication

Food Allergy Action Plan

Place Child's Picture Here

Student's Name:_____ **D.O.B:**_____ **Teacher:**_____

ALLERGY TO:_____

Asthmatic Yes* ☐ No ☐ *Higher risk for severe reaction

◆ STEP 1: TREATMENT ◆

Symptoms:	Give Checked Medication**: **(To be determined by physician authorizing treatment)
▪ If a food allergen has been ingested, but *no symptoms*:	☐ Epinephrine ☐ Antihistamine
▪ Mouth Itching, tingling, or swelling of lips, tongue, mouth	☐ Epinephrine ☐ Antihistamine
▪ Skin Hives, itchy rash, swelling of the face or extremities	☐ Epinephrine ☐ Antihistamine
▪ Gut Nausea, abdominal cramps, vomiting, diarrhea	☐ Epinephrine ☐ Antihistamine
▪ Throat† Tightening of throat, hoarseness, hacking cough	☐ Epinephrine ☐ Antihistamine
▪ Lung† Shortness of breath, repetitive coughing, wheezing	☐ Epinephrine ☐ Antihistamine
▪ Heart† Weak or thready pulse, low blood pressure, fainting, pale, blueness	☐ Epinephrine ☐ Antihistamine
▪ Other† _____	☐ Epinephrine ☐ Antihistamine
▪ If reaction is progressing (several of the above areas affected), give:	☐ Epinephrine ☐ Antihistamine

†Potentially life-threatening. The severity of symptoms can quickly change.

DOSAGE

Epinephrine: inject intramuscularly (circle one) EpiPen® EpiPen® Jr. Twinject® 0.3 mg Twinject® 0.15 mg (see reverse side for instructions)

Antihistamine: give_____
medication/dose/route

Other: give_____
medication/dose/route

IMPORTANT: Asthma inhalers and/or antihistamines cannot be depended on to replace epinephrine in anaphylaxis.

◆ STEP 2: EMERGENCY CALLS ◆

1. Call 911 (or Rescue Squad: _____). State that an allergic reaction has been treated, and additional epinephrine may be needed.

2. Dr. _____ Phone Number: _____

3. Parent_____ Phone Number(s) _____

4. Emergency contacts:

Name/Relationship	Phone Number(s)	
a. _____	1.)_____	2.) _____
b. _____	1.)_____	2.) _____

EVEN IF PARENT/GUARDIAN CANNOT BE REACHED, DO NOT HESITATE TO MEDICATE OR TAKE CHILD TO MEDICAL FACILITY!

Parent/Guardian's Signature_____ Date_____

Doctor's Signature_____ Date_____
(Required)

Plan de Emergencia Contra Alérgenos Alimenticios

Nombre del estudiante: _____

Fecha de nacimiento: _____ **Profesor:** _____

ALERGIA: _____

Coloque la foto del niño aquí.

Asmático Sí* ☐ No ☐ *Alto riesgo de sufrir una reacción alérgica grave

◆ PASO 1: TRATAMIENTO ◆

Síntomas:		Administre el medicamento indicado**: **(Sera determinado por el medico que autorice el tratamiento)
Si ha ingerido un alérgeno alimenticio pero *no aparecen síntomas*:		☐ Epinefrina ☐ Antihistamínico
Boca	Picazón e inflamación en los labios, la lengua, o boca	☐ Epinefrina ☐ Antihistamínico
Piel	Ronchas, erupción de la piel con picazón y/o hinchazón en la cara o extremidades	☐ Epinefrina ☐ Antihistamínico
Intestino	Náusea, retortijón abdominal, vómitos y/o diarrea	☐ Epinefrina ☐ Antihistamínico
Garganta†	Picazón y/o sensación de tirantez en la garganta, ronquera y tos seca recurrente	☐ Epinefrina ☐ Antihistamínico
Pulmón†	Falta de respiración, tos repetitiva y/o respiración sibilante	☐ Epinefrina ☐ Antihistamínico
Corazón†	Pulso filiforme, desmayo, palidez, baja presión, piel azulada	☐ Epinefrina ☐ Antihistamínico
Otro†	_____	☐ Epinefrina ☐ Antihistamínico
Si la reacción avanza (afectando a varias de las áreas arriba mencionadas), administre:		☐ Epinefrina ☐ Antihistamínico

La gravedad de los síntomas puede cambiar rápidamente. †Estos síntomas pueden progresar y poner en peligro su vida.

DOSIS

Epinefrina: inyecte el EpiPen®, EpiPen® Jr., Twinject® 0.3 mg, o Twinject® 0.15 mg por vía intramuscular (indique uno). (Si desea consultar las instrucciones completas, lea al dorso)

Antihistamínico: administre _____
medicamento/dosis/vía de administración

Otro: administre _____
medicamento/dosis/vía de administración

AVISO IMPORTANTE: En caso anafilaxia, usted no puede confiar en el uso de inhaladores y/o antihistaminas como reemplazos de la epinefrina.

◆ PASO 2: LLAMADAS DE EMERGENCIA ◆

1. Llame al 911 o al servicio público de ambulancias (Rescue Squad). Indique que la reacción alérgica ha sido tratada pero que puede ser necesaria una dosis adicional de epinefrina.

2. Dr. _____ al _____

3. Contactos de emergencia:

	Nombre/Parentesco familiar	Teléfono(s)	
a.	_____	1.)_____	2.) _____
b.	_____	1.)_____	2.) _____

Food Allergy Awareness

Eight foods account for 90% of all allergic reactions:


Peanuts


Tree Nuts


Milk


Eggs


Wheat


Fish


Shellfish


Soy

However, any food can cause a reaction.

Did You Know?

- One out of every 25 Americans has a food allergy
- It is estimated that between 150 and 200 people die annually from food allergy reactions or anaphylaxis; including children and young adults
- You should take all food allergy reactions seriously

The Food Allergy & Anaphylaxis Network
11781 Lee Jackson Hwy., Suite 160
Fairfax, VA 22033-3309
Phone: (800) 929-4040 • Fax: (703) 691-2713
E-mail: faan@foodallergy.org • Web site: www.foodallergy.org

FOOD ALLERGY AWARENESS

Foods that most often cause an allergic reaction:

PEANUTS	MILK
TREE NUTS	EGGS
WHEAT	FISH
SOY	SHELLFISH

However, other, less common foods can also cause allergic reactions. Reactions can range from mild to deadly.

Anaphylaxis is a serious allergic reaction that is rapid in onset and may cause death. The most common causes of anaphylaxis are food, medication, insect stings, and latex.

Common warning signs and symptoms of an anaphylactic reaction:

- Complaint of a tingling, itchiness, or metallic taste in the mout
- Hives
- Difficulty breathing
- Swelling and/or itching of the mouth and throat area
- Diarrhea
- Vomiting
- Cramps and stomach pain
- Paleness (due to a drop in blood pressure)
- Loss of consciousness

If you see someone showing any of these symptoms

Administering inhalation medications

Metered dose inhalers disperse fine mist into the air passageways. Air exchange takes place deep in the lungs. The deeper portions of the lungs also provide a larger area for medication absorption. With this in mind, when administering inhalation medications it is important for the student to expel all the air out of his/her lungs before breathing in. This can be a hard concept for children to learn; therefore, the nurse must provide teaching to the student prior to administration.

Routine/Prophylactic asthma inhaler

This inhaler should be give at home. This medication is not meant to be used in an emergency situation, therefore to decrease confusion, it is best to have the parent administer the medication prior the ths student coming to school.

Emergency/Rescue inhaler

1. Shake the inhaler well before administration.
2. If a spacer is used place the inhaler into the spacer.
3. Fit the spacer around the student's nose and mouth, or have the student place mouth around the tube of the spacer depending on which type the student uses.
4. Tell the student to blow out all the air in his/her lungs and take in a deep breath.
5. As the child breathes in, press firmly on the inhaler to activate the medication.
6. Repeat this procedure as often as the prescription states to.
7. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date
    b. Time
    c. Name of medication
    d. Who gave the medication

Administering Eye drops

1. Explain the procedure to the student to decrease anxiety about eye drops.
2. Assist the student to a comfortable position.
3. Apply gloves.
4. Clean the eyelid and the eyelashes with a wet cotton ball.

5. Wipe from the inner eye (closest to the nose) to the outer eye.
6. Have student look up toward the ceiling.
7. Gently pull the lower eyelid down with the non-dominant hand.
8. With the dominant hand, put drops into the eyelid and release.

   Assure the tip of the medication bottle does NOT touch the eye, as this will contaminate the medication*
9. If needed pat the eyelids with a tissue. DO NOT rub the eye.
10. Wash hands.
11. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date
    b. Time
    c. Name of medication
    d. Who gave the medication

Administering ear drops

1. Explain the procedure to the student.
2. Apply gloves.
3. Assist the student to a comfortable position.
4. Gently pull the ear lobe downward.
5. Squeeze medication into the ear canal.
6. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date
    b. Time
    c. Name of medication
    d. Who gave the medication

Administering Topical Medications:

1. Powder: sprinkle a thin layer over the skin and cover.
2. Lotions: use a swab and apply a small amount over the affected area.
3. Aerosol: hold the can approximately 6-12inches from skin and spray.
4. Transdermal Patch: clean and dry skin, remove patch from adhesive, making sure not to touch the medication, place patch on skin.
5. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date
    b. Time
    c. Name of medication
    d. Who gave the medication

Administering Medications per Gastrostomy tube

1. Dissolve crushed/broken medication in warm water.
2. Open capsules (only when allowed) and mix the contents with water.
3. Do not administer whole or un-dissolved medications through the G-tube.
4. Connect catheter-tip syringe to gastrostomy tube.
5. Connect catheter-tip syringe to gastrostomy tube.
6. If giving several medications, flush with 3cc of water between medications.
7. When complete, flush with 5cc of water to clear the tube.
8. DOCUMENT MEDICATION ADMINISTRATION. All of the following MUST be documented on the Medication Administration Record:
    a. Date
    b. Time
    c. Name of medication
    d. Who gave the medication

Medication Administration (ASBN 4.0) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Oral—prescription (4.1)			
1. Assemble supplies			
2. Verify child's ability to take oral medications			
3. Verify accuracy of medication			
a. Right Name			
b. Right Medication			
c. Right Dose			
d. Right Time			
e. Right Route			
4. Prepare the medication **only crush or break apart if RN has verified the medication properties allow this			
5. Shake liquid medication well to mix			
6. Cover the label of the bottle and pour appropriate dose			
7. Administer the medication			
8. DOCUMENT PROCEDURE			
Over-the-counter medications (4.2)			
1. Follow the procedure listed above			
2. Administer the medication EXACTLY as directed on the package			
3. DOCUMENT PROCEDURE			
Injections (4.3)			
DO NOT DELEGATE			

EpiPen® Allergy Kit (4.4)			
1. Initiate Emergency Response—Call 9-1-1			
2. Pull of gray activation cap			
3. Grasp the injector with a fist around the barrel			
4. Hold black tip near outer thigh			
5. Swing and jab firmly into outer thigh until Auto-injector mechanism functions. Hold in place and count to 10.			
6. Remove the EpiPen ®			
7. DOCUMENT PROCEDURE			
Inhalation (4.5)			
Routine Inhalers (4.5.1) should be administered at home			
Emergency/Rescue inhalers (4.5.2)			
1. Shake the inhaler well			
2. Place the inhaler into the spacer if used			
3. Fit spacer around student's nose and mouth, or have the student place mouth around the tube of the spacer depending on which type the student uses.			
4. Tell the student to blow out all the air in his/her lungs and take in a deep breath			
5. As the child breathes in, press firmly on the inhaler to activate the medication			
6. Repeat this procedure as often as the prescription states to			
7. DOCUMENT PROCEDURE			
Nasal Insulin (4.5.3)			
DO NOT DELEGATE			
Nasal controlled substance (4.5.4)			
DO NOT DELEGATE			
Rectal medications (4.6)			
DO NOT DELEGATE			

Bladder instillation (4.7)			
DO NOT DELEGATE			
Eye Drops (4.8)			
1. Explain the procedure to the student			
2. Assist the student to a comfortable solution			
3. Apply gloves			
4. Clean the eyelid and eyelashes with a wet cotton ball			
5. Wipe from the inner eye to the outer eye			
6. Have the student look up toward the ceiling			
7. Gently pull the lower eyelid down with the non-dominant hand			
8. With the dominant hand, put drops into the eyelid and release			
9. Pat the eyelid with tissue if needed			
10. Wash hands			
11. DOCUMENT PROCEDURE			
Ear Drops (4.8)			
1. Explain the procedure to the student			
2. Apply gloves			
3. Assist the student to a comfortable position			
4. Gently pull the ear lobe downward			
5. Squeeze medication into the ear canal			
6. Have student sit there for 10 seconds			
7. DOCUMENT PROCEDURE			
Topical (4.9)			
1. Powder: sprinkle a thin layer over the skin and cover			
2. Lotions: use a swab and apply a small amount over the affected area			

3. Aerosol: hold can approximately 6-12inches from skin and spray			
4. Transdermal Patch: clean and dry skin, remove patch from adhesive, making sure not to touch the medication, place patch on skin.			
5. DOCUMENT PROCEDURE			
Per Naso-Gastric Tube (4.10)			
DO NOT DELEGATE			
Per Gastrostomy Tube (4.11)			
1. Dissolve crushed/broken medication in warm water			
2. Open capsules (only when allowed) and mix the contents with water			
3. Do not administer whole or un-dissolved medications through the G-tube			
4. Connect catheter-tip syringe to gastrostomy tube			
5. Connect catheter-tip syringe to gastrostomy tube			
6. Administer medication through G-tube			
7. If giving several medications, flush with 3cc of water between medications			
8. When complete, flush with 5cc of water to clear the tube			
9. DOCUMENT PROCEDURE			
Intravenous (4.12)			
DO NOT DELEGATE			

Section IX

Ostomies

Ostomy

An ostomy is “a surgical procedure where the elimination of stool or urine is re-routed from the usual exiting part of the client. Instead, the stool or urine exits the body through a surgically created opening called a stoma” (Perry & Potter, 2006, p.1563). There are several names for Ostomies which are based on where they are located in the digestive system.

1. Iliostomy: this is ostomy is created by diverting the contents from the small intestine. The stool has a liquid consistency since it contains stomach acids and will drain freely. A pouch is needed to contain the material.

2. Colostomy: this ostomy can be located in multiple sections of the colon.

Ostomy Care

Because the care of students with Ostomies is extremely student specific, it is critical to have the parent/guardian give instructions for care of the ostomy. A bland skills procedure checklist will be provided so that a student-specific checklist can be created.

Ostomy Care (ASBN 5.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y/ N	Date	Date

Checklist reviewed and approved by Parent and School Nurse

_____Parent Signature /Date

_____School Nurse Signature /Date

DO NOT DELEGATE

Under the Arkansas State Board of Nursing Delegation guidelines this task MUST be performed by a licensed individual.

Section X

Respiratory

Postural Drainage and Percussion

Postural drainage is a technique used to facilitate drainage of secretions from the airway. This procedure can be achieved through several techniques and is highly dependent on position of the individual as to which section of the lungs will be affected. A procedure known as chest physiotherapy (CPT) uses percussion, vibration and shaking to loosen secretions so they may be forced into the larger airways which make it easier to expel. This procedure is performed on specific areas of the chest depending on which part of the lung is affected. Percussion uses the hand to create a cupping motion which sends vibrations throughout the area to loosen secretions.

This skill is highly student specific, therefore a blank skills checklist is provided so the nurse and the parent/guardian may create the appropriate checklist.

Suctioning

Sometimes it may be necessary to suction secretions from the mouth or tracheostomy. Suctioning may be performed with a suction machine or a bulb syringe.

Procedure for Suctioning

1. Identify the student's ability to assist in the procedure.
2. Gather supplies.
    a. Suction machine with tubing.
    b. Catheter.
    c. Cup of tap water or saline.
    d. Bulb syringe.
    e. Gloves.
    f. Plastic bag for disposal.
3. Wash hands.
4. Apply gloves.
5. Position student and explain procedure.
6. Turn on suction machine and check function.
7. Attach catheter to suction tubing.
8. Insert catheter into nose and advance until student coughs without suction

    Note: if resistance is met, DO NOT proceed with catheter—the nose bleeds easily

    ***For **Tracheostomy suctioning**, place the catheter into the tracheostomy tube and proceed with the same steps for the remainder of the procedure

9. Apply suction. When the student coughs, withdraw catheter while twirling the catheter.
10. Put a few drops of normal saline into the nose to thin secretions if they are thick.
11. Repeat suctioning in this order until secretions are cleared.
12. Suction the mouth by advancing catheter into the mouth without suction.
13. Apply suction and withdraw the catheter while twirling.
14. Repeat suctioning in this order until all secretions are cleared.
15. Dispose of catheter.
16. Rinse tubing with tap water.
17. Remove gloves and wash hands.
18. DOCUMENT PROCEDURE
19. Notify RN of any changes in the student's condition or any other concerns.

Procedure for Suctioning with a bulb syringe

1. Identify the student's ability to participate in the procedure.
2. Gather supplies.
    a. Bulb syringe.
    b. Saline.
    c. Tissues.
    d. Gloves.
3. Wash hands.
4. Apply gloves.
5. Position the student and explain the procedure.
6. Squeeze the bulb syringe and place the tip gently in the nose or mouth and release.

    ***For **Tracheostomy suctioning**, place the bulb into the tracheostomy tube and follow the same steps for the remainder of the procedure
7. Remove the bulb syringe from the nose or mouth.
8. Squeeze the bulb syringe into the tissue, expelling secretions. Repeat steps 6-8 until all secretions have been removed.
9. Clean the bulb syringe and dispose of the tissue.
10. DOCUMENT PROCEDURE

11. Notify the RN of any changes in the student's condition or any other concerns.

Tracheostomy Tube Replacement and Care

1. Identify the student's ability to participate in the procedure.
2. Gather supplies.
    a. Tracheostomy tie or tracheostomy tube holder.
    b. One half hydrogen peroxide and one half normal saline or distilled water mixture.
    c. Cotton-tipped applicators.
    d. Pipe cleaners.
    e. Tracheal gauze or sponges.
    f. Two clean containers.
    g. Gloves.
3. Wash hands.
4. Apply gloves.
5. Position the student and explain the procedure.
6. Remove old gauze or sponges from the tracheostomy.
7. Clean the stoma with hydrogen peroxide mixture with cotton swabs.
8. If the tracheostomy has an inner cannula, remove the inner cannula.
9. Replace old tracheostomy ties or holder with a new one.
10. Insert tracheostomy sponge under the tracheostomy tube phalanges.
11. Clean the inner cannula with the hydrogen peroxide mixture and the pipe cleaners.
12. Rinse with saline.
13. Replace the inner cannula and lock into place.
14. Discard the cleaning solution.
15. Remove gloves.
16. DOCUMENT PROCEDURE.
17. Report any changes or concerns to the RN.

Suctioning (ASBN 6.3.1 and ASBN 6.3.2) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Pharyngeal (6.3.1) and Tracheostomy (6.3.2) Suctioning			
1. Identify the student's ability to assist in the procedure			
2. Gather supplies			
3. Wash hands			
4. Apply gloves			
5. Position student and explain procedure			
6. Turn on suction machine and check function			
7. Attach catheter to suction tubing			
8. Insert catheter into nose and advance until student coughs without secretions			
****For tracheostomy suctioning, place catheter into the tracheostomy and continue			
9. Apply suction. When the student coughs, withdraw catheter while twirling			
10. If secretions are thick, put a few drops of saline into the nose or tracheostomy			
11. Repeat suctioning in this order until secretions are cleared			
12. Suction the mouth by advancing the catheter into the mouth without suction			
13. Apply suction and withdraw the catheter while twirling			
14. Repeat suctioning in this order until all secretions are cleared			
15. Dispose of catheter			
16. Rinse tubing with tap water			
17. Remove gloves and wash hands			

18. Notify RN of any changes or concerns			
19. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature& Date

_____Nurse Signature & Date

Suctioning with a bulb syringe (ASBN 6.3.1 and ASB 6.3.2 continued) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Suctioning with a bulb syringe (pharyngeal and tracheostomy)			
1. Identify the student's ability to assist in the procedure			
2. Gather supplies			
3. Wash hands			
4. Apply gloves			
5. Position student and explain procedure			
6. Squeeze the bulb syringe and place the tip into the nose or mouth and release			
****For tracheostomy suctioning, place bulb syringe into the tracheostomy and continue			
7. Remove the bulb syringe from the nose or mouth			
8. Squeeze the bulb syringe into the tissue, expelling secretions			
9. If secretions are thick, put a few drops of saline into the nose or tracheostomy			
10. Repeat suctioning in this order until secretions are cleared			
11. Clean the bulb syringe and dispose of the tissue			
12. Remove gloves and wash hands			
13. Notify RN of any changes or concerns			
14. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Tracheostomy Tube Replacement and Care (ASBN 6.3.3 and ASBN 6.3.4)

School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Tracheostomy tube replacement and care			
1. Identify the student's ability to assist in the procedure			
2. Gather supplies			
3. Wash hands			
4. Apply gloves			
5. Position student and explain procedure			
6. Remove old gauze or sponges from the tracheostomy			
7. Clean the stoma with the hydrogen peroxide mixture with cotton swabs			
8. If the tracheostomy has an inner cannula, remove the inner cannula			
9. Replace old tracheostomy ties or holder with a new one			
10. Insert the inner tracheostomy sponge under the tracheostomy tube phalanges			
11. Clean the inner cannula with the hydrogen peroxide mixture and pipe cleaners			
12. Rinse with saline			
13. Replace the inner cannula and lock into place			
14. Discard the cleaning solution			
15. Remove gloves and wash hands			
16. Notify RN of any changes or concerns			
17. DOCUMENT PROCEDURE			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Section XI

Screenings

Please refer to the School Nurse guidelines and individual training materials for requirements regarding the following screenings:

1. Growth (ASBN 7.1)
2. Hearing (ASBN 7.3)
3. Vision (ASBN 7.4)
4. Scoliosis (ASBN 7.5)

Vital Signs may be delegated. The unlicensed assistive personnel may ONLY *obtain values* and *report* them to the RN. The RN MUST be the one to determine further indications for treatment.

The RN must demonstrate the correct procedures for each procedure

1. Obtaining a Respiratory Rate (RR)
2. Obtaining a Heart Rate (HR)
3. Obtaining a Blood Pressure (BP)

Once demonstration of the correct procedure has been accomplished, the RN MUST observe the unlicensed assistive personnel perform the task. It is up to the RN to determine when successful competency has been reached.

Vital Signs (ASBN 7.2) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Heart Rate			
1. Have the student sit in a chair or lie on the health bed			
2. Place index finger on the radial pulse			
3. Count number of beats for one minute			
4. Record the number and notify RN if less than _____bpm and more than _____bpm			
5. Notify RN of findings			
Respiratory Rate			
1. Have the student sit in a chair or lie on the health bed			
2. Place hand in the center of the chest and feel for the rise and fall with each breath ***Note: it may be necessary to watch the rise and fall of the chest while you keep your fingers on the radial pulse, so that the student is not aware of the observation of respiratory rate*			
3. Count the number of times the chest rises for one minute			
4. Notify the RN of findings			
Blood Pressure			
1. Determine the appropriate size cuff to use			
2. Wrap the cuff around the student's middle upper arm and make sure the arrow points to the brachial artery			
3. Place the sthethoscope on the brachial artery			
4. Close the circuit on the bulb and pump until the needle reaches _____mmHg (millimeters of mercury)			
5. Slowly release the air out of the cuff while listening for the first audible beat			
6. Remember the number			
7. Listen for the last audible beat and remember the number			
8. Release all the air from the bulb			
9. Document the blood pressure with the first # on top and the second # on bottom. (xxx/xx)			
10. Notify RN of findings			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Blood glucose testing

This procedure is mainly used for those students who monitor blood sugar for Diabetes. Follow the student-specific Health Care Plan for this procedure.

Procedure for Blood glucose testing

1. Wash hands.
2. Gather supplies:
    a. Paper towel
    b. Gloves
    c. Test strips
    d. Lancets
    e. Blood glucose meter
    f. Alcohol swab
    g. Tissue
3. Position student in a chair or on the health bed and have them hang their hand down.
4. Apply gloves.
5. Select finger to use (try not to use the same finger used during the last test).
6. Wipe the tip of the finger with the alcohol swab and allow to air dry.
7. Turn the glucose meter on.
8. Place the reagent strip into the meter.
9. Use the lancet to puncture the skin and allow a drop of blood to form. Use the reagent strip to obtain the drop of blood for testing.
10. Wait for the results to show and record the reading onto the student's log.
11. Follow the student specific Health Care Plan for appropriate actions.

Procedure for collecting urine glucose

1. Wash hands.
2. Gather supplies:
    a. Urine cup
    b. Urine reagent strips
    c. Catheter tipped syringe
    d. Paper towel or tissue
3. Apply gloves.
4. Have student collect urine specimen in a cup.

    *****Note: if student is incontinent and wears a diaper, change the students diaper and save the urine soiled diaper. You can use the catheter tipped syringe to gather urine from the diaper. Simply place the tip of the catheter against the diaper and pull the plunger back. You may have to repeat this process several times; however you will be able to get enough urine for the reagent strip.*

5. Have a reagent strip ready on a paper towel or tissue with the square pads facing up.
6. Use the catheter tipped syringe to obtain a sample of urine and place one drop of urine on each section of the reagent test strip.
7. Allow the urine to sit on the test strip according to the directions then turn the reagent strip on its side allowing the urine droplets to fall onto a tissue or towel.
8. Compare the colors on the reagent strip with the color indicators on the side of the reagent strip bottle and record findings.
9. Follow the student specific Health Care Plan for further directions.

Specimen Collecting (ASBN 8.0) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Blood Glucose Testing (8.1)			
1. Wash hands			
2. Gather supplies			
3. Position student in a chair or health bed and hang hand down			
4. Apply gloves			
5. Select finger to use for testing			
6. Wipe the tip of the finger with the alcohol swab and air dry			
7. Turn the glucose monitor on			
8. Place the reagent strip into the meter			
9. Use the lancet to puncture the skin and obtain blood drop with the reagent strip			
10. Wait for the results and record the reading			
11. Use the student specific Health Care Plan for appropriate actions			
Urine Glucose Testing (8.2)			
1. Wash hands			
2. Gather Supplies			
3. Apply gloves			
4. Collect urine specimen (student or diaper)			
5. Have a reagent strip on a paper towel or tissue with the pads facing up			
6. Use the catheter tipped syringe to collect urine and place one drop on the appropriate square pad sections			
7. Allow the urine to sit on the reagent strip according to the directions			
8. Compare the colors on the reagent strip with the color indicators on the side of the reagent strip container and record findings			
9. Follow the student specific Health Care Plan for further directions.			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Section XIII

Other Healthcare Procedures

Seizures

Seizures are one of the most prevalent nervous system disorders in America today. “While epilepsy can develop at any time of life, the occurrence of new cases is more common in children and in people older than 60 years of age (Epilepsy classroom, 2008 p.2). A diagnosis of epilepsy is not delivered unless there has been more than one episode of seizure activity without a mitigating factor (i.e, fever, medication induced, etc…). A seizure can be defined as “the physical manifestation of a sudden disruption of orderly communication between neurons in the brain [and] can take a variety of forms, depending on where the disruption occurs and how far the resulting abnormal electrical activity spreads (Epilepsy classroom, 2008, p.2).

Partial seizures

- ✓ Affect one area of the brain in one hemisphere
- ✓ May or may not have loss of consciousness
- ✓ Muscle twitching, repetitive motions, and ‘daydreaming’
- ✓ May become generalized

Generalized seizures

- ✓ Affect both hemispheres
- ✓ Loss of consciousness
- ✓ Blank stares, falling to the floor, sudden jerking movements and repetitive stiffening and relaxing of muscles

Absence seizures

- ✓ Most common in children
- ✓ Brief disruption of consciousness with blank stare, the eyes may roll forward and lack of response
- ✓ Previously referred to as petit mal seizures

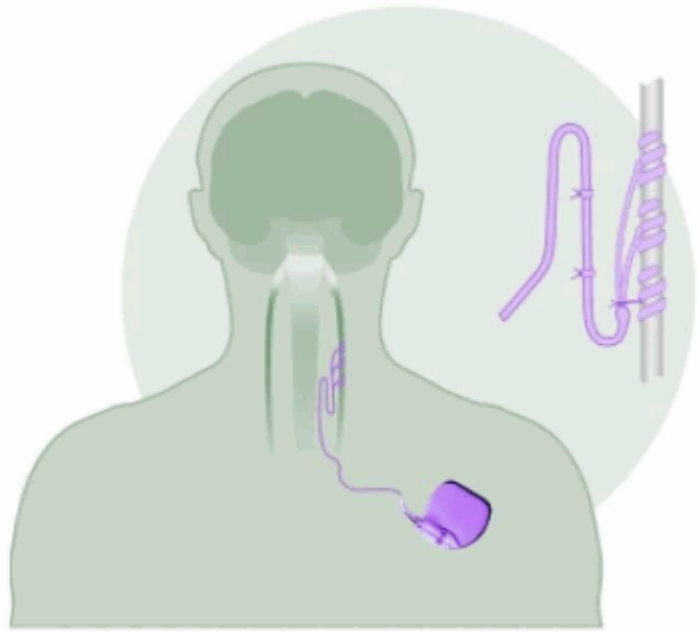
Key points to remember when a child is having a seizure

1. Remain calm.
2. Help the child to the floor.
3. Move objects away from the child.
4. DO NOT put anything into the child’s mouth.
5. Once the jerking movements have stopped turn the child on his/her side.

6. Follow the student-specific Health Care Plan for length of seizure activity before medication administration needs to be considered.

7. Stay with the student until he/she is fully alert.

Vagus Nerve Stimulation



The Epilepsy foundation provides an in-depth resource for vagus nerve stimulation. This form of therapy is used when medications do not control seizures and the individual is not a candidate for surgery. Currently the Food and Drug administration has approved VNS in adults and children over the age of 12.

The VNS is a flat battery which is surgically implanted in the chest wall close to the collar bone. Thin wires are then fed to the Vagus nerve in the neck. These wires send small amounts of electrical pulses to the brain. The battery is programmed to deliver a set amount of electricity at set intervals. Once the device has been implanted a physician can re-program the device from outside of the skin. If an individual feels a seizure approaching, he/she can pass a magnet over the device to activate the stimulation. This may not always stop a seizure from occurring but can make the duration and intensity shorter. If the magnet is passed over the device during an active episode, the seizure may be stopped. The magnet can be clipped to a belt or worn as a watch. Here is a picture of what one might look like.

Because the use of a Vagus nerve stimulator is extremely student specific a blank skills checklist is provided so the RN and the parent/guardian can create the proper procedure.

Seizure Safety Precautions (ASBN 9.1) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Seizure Safety Precautions (9.1)			
12. Remain Calm			
13. Help the child to the floor			
14. Move objects away from the child			
15. DO NOT put anything into the child's mouth			
16. Once the jerking movements have stopped, turn the child onto his/her side			
17. Follow the student specific Health Care Plan for length of seizure activity before medication administration should be considered			
18. Stay with the student until he/she is fully alert			
19. Documents episode including:			
a. Time of onset			
b. Length of episode			
c. Loss of consciousness			
d. Loss of bowel/bladder continence			
e. Did the student return to pre-episode state of alertness			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Vagus Nerve Stimulation (ASBN 9.5) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Pressure Ulcers

"According to the National Pressure Ulcer Advisory Panel (NPUAP), a pressure ulcer is defined as a localized area of tissue destruction that develops when soft tissue …is compressed between a bony prominence and an external surface, for a prolonged period of time" (Butler, 2006, ¶ 1). Essentially when the blood supply to the skin is diminished for a period of time tissue death begins to occur and an ulcer begins to form. The primary goal in treatment of pressure areas is to determine the cause and eliminate the problem before an ulcer is formed. There are several factors which contribute to the formation of ulcers

1. Friction
2. Prolonged pressure on one area
3. Shearing
4. Moisture contact with the skin for extended periods of time

Treatment of pressure ulcers depends on the severity of tissue involvement. Each wound is assessed by the physician to determine the appropriate course of skin barriers and wound cleansers. Once the wound has been assessed a specific treatment plan will be developed for treatment.

Due to the student specific treatment a blank skills checklist is available so the parent/guardian and the nurse may collaborate to create the proper procedure.

Pressure Ulcer Care (ASBN 9.2) School Year_____

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Pressure Ulcer Care			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Dressing Changes--Sterile (ASBN 9.3) School Year_____

Dressing Changes—Non-Sterile (ASBN 9.4)

Student's Name: _____

Trainee: _____

Nurse: _____

Explanation and Return Demonstration of procedure	Y / N	Date	Date
Dressing Change—Sterile (ASBN 9.3)			
1. Explain procedure to student			
2. Expose area with the wound—assure only enough skin is exposed to gain access to the wound			
3. Wash hands and apply gloves			
4. Remove soiled dressing and dispose			
5. Remove gloves and dispose			
6. Set up sterile field			
7. Apply sterile gloves			
8. Open all packages an 'plop' equipment needed onto sterile field			
9. If ordered, cleanse the wound area with appropriate cleansing agent			
10. Pat area dry with a towel			
11. Apply the antiseptic ointment as prescribed			
12. Apply sterile dressing to wound, apply adhesive tape to the dressing to secure dressing in place			
13. Remove gloves			
14. Wash hands			
15. Document Procedure and notify RN of any changes or concerns			
Dressing Change—Non-Sterile			
1. Explain procedure to student			
2. Expose area with the wound—assure only enough skin is exposed to gain access to the wound			
3. Wash hands and apply gloves			
4. Remove soiled dressing and dispose			
5. If ordered, cleanse the wound area with appropriate cleansing agent			
6. Pat area dry with a towel			
7. Apply antiseptic ointment as prescribed			
8. Apply clean dressing to the wound and apply adhesive tape to secure dressing in place			
9. Remove gloves and Wash hands			
10. DOCUMENT PROCEDURE and notify RN of any questions or concerns			

This checklist has been reviewed and approved by the Parent and School nurse.

_____Parent Signature & Date

_____Nurse Signature & Date

Section XII

Developing Protocols

Healthcare Procedures (ASBN 10.1)

Emergency Protocols (ASBN 10.2)

Individualized Healthcare Plans (ASBN 10.3)

DO NOT DELEGATE

Under the Arkansas State Board of Nursing Delegation guidelines this task MUST be performed by a licensed individual.